

October 1954

Medical Economics

Can You Drive



See in this issue:

Labor Health Centers

Depreciation

When Is a Fee Excessive?

Rx INFORMATION

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References: 1. Gennari, R. B.: Ann. Internal Medicine, 53: 130, June 1960.
2. Andrew, R. B.: New England J. Med., 272: 322, 1964.
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4. Scott, H. L.: J. Mat. Sci., N.Y., 1964.

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Medical Economics

AN INDEPENDENT NATIONAL BUSINESS MAGAZINE FOR PHYSICIANS

When Is a Fee Excessive?	97
The courts have often found this a difficult question to answer; but here are some pointers that should help you arrive at a judgment for yourself	
The Car You Drive	100
It's probably a mere Ford (not a Cadillac) and a couple of years old. What's more, most doctors don't prefer sedate black sedans—as this MEDICAL ECONOMICS survey reveals	
Are Labor Health Centers a Threat to M.D.s? ..	109
More and more unions are dispensing 'complete' care these days; and some physicians say they are frankly worried by what they consider the handwriting on the wall	
A Well-Planned Office for a Family Doctor	119
Imaginative treatment of layout and furnishings helps make this an efficient—though in some ways unconventional—set-up for solo practice	
The Man Who Creates Rex Morgan	126
A young doctor dreamed up this 'purposely uncomical comic strip.' Today it's a hit with funnies fans all over the U.S.—and with real-life physicians, too	
How Your Savings Grow	132
If you're hopefully laying a nest egg for retirement, these tables will help you to gauge its size	
I Shoot Patients	137
The author's weapon is a camera, of course. And pictures like the ones she snaps have proved so useful to doctors that many of them now make their own	
Figuring Depreciation Under the New Tax Law	146
Revised rules for faster write-offs will give some doctors a strong incentive to replace old equipment. Here's why	

MORE ON NEXT PAGE

CONTENTS
(Cont.)

Murphy Is a Drip.....	153
Plenty of doctors give their names to syndromes, tests, or diseases. Semantically speaking, the result is an eponym. Medically speaking, it's just plain confusing	
A New Crop of Country Doctors	161
Illinois M.D.s and farmers have recently linked arms to solve a problem of the soil: replenishing the state's depleted supply of rural physicians	
Do You Scare 'em to Death?	172
Strange-looking instruments and double-edged medical terms can give your patients a bad time	
Choosing a Location: the Office Site	181
These resettlement experiences of other medical men may help guide you in your selection of the most desirable neighborhood and building	
How Much Security Is Enough?	199
At what point should government call a halt to its responsibility for a man's welfare? Social legislation will surely be overextended unless this question is answered—and answered soon—the author declares	
Thirteen Hints on Heating	212
Do you want to cut your fuel bills? And put real efficiency into your heating system? Here's the way a heating engineer would tell you to do it	
I Joined the Human Race	227
A Negro physician from the South tells of his heartwarming experience as a resident at a large Northern hospital	

DEPARTMENTS

Panorama	4
Letters	45
Editorials	77
News	277
Semi-annual Index	301
Memo From the Publisher	320

153	NEWS INDEX
161	Warns Against Illegal Diathermy Equipment 277
172	'Doctors Need Protection From A.M.A. Power' 277
181	Industrial Physicians Look To New Institute 281
199	'G.P.s Save You Money,' Says This G.P. 285
212	Doctors Get Group Rates Under Blue Cross 288
227	Raps Psychiatrists Who Charge Other M.D.s 288
	No Whistling, Please 289
	Advises Closer Study of Patient's Personality 289
	British M.D. Reports on American G.P.s 290
	Sees Too Much Medical Advice in Magazines 298
	P.G. Program Works 'Like a Circus' 299

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Panorama

Doctors star in new TV

series • Forecasts dim future for surgeons • M.D. raps Administration • 1955 cars previewed • Blue Shield loses ground

T-Men Are Watching You

If you own a Cadillac, a yacht, or a plane—or if you're about to give your daughter a lavish coming-out party—you'd better make sure that your Federal income tax returns are in apple-pie order. That's the latest word from Commissioner of Inter-

nal Revenue T. Coleman Andrews.

Such signs of luxurious living usually make T-men look twice, Andrews recently told a Congressional subcommittee. And he cited this case to prove it:

One of his agents spotted an unlikely-looking individual "riding around in a pretty expensive automobile." So the agent did a bit of investigating—and discovered that the fellow was a wealthy "member of a profession, although he didn't look it." The investigation also showed that the man had been defrauding the Government for a long time: In none of the past six years had he paid more than \$18 in income taxes.

"That gentleman got checked," said Commissioner Andrews, primarily because "he was making . . . a show of his position."

The same test is apparently being applied to owners of yachts and planes. Their names are being taken from registration records in Washington and sent to district tax collectors. "The fact [that these people] are registered as owning a yacht or airplane is to be taken into



CADILLACS catch tax agent's eye,
says T. Coleman Andrews.

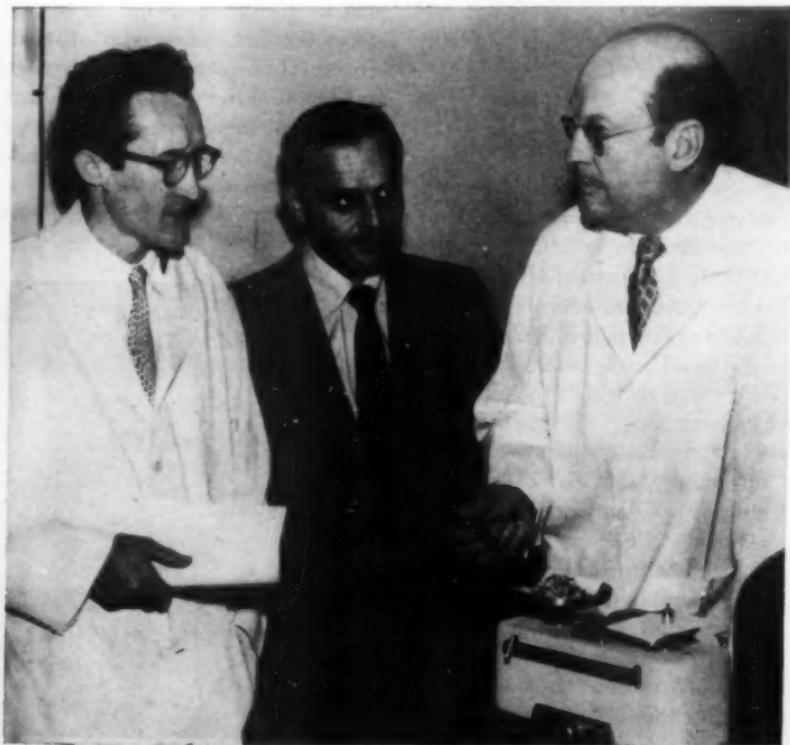
account" when their tax returns are audited, Commissioner Andrews says.

TV Series Stars M.D.s

Medicine is once more having its day on TV—this time in a series of dramatic case histories called "Medic." The half-hour show, which got under way on a national network

last month, has been filmed on real-life locations in and around Los Angeles; actual doctors and nurses appear in the cast. Result, as noted by audiences so far: a remarkable flavor of authenticity.

Responsible for much of this realism is the show's writer, James Moser, who originally wrote the equally compelling "Dragnet" series. To gather material for "Medic,"



DISCUSS NEW TV SHOW: James Moser, left, writer of "Medic," confers with Frank La Tourette, producer, and Dr. J. P. Sampson of Los Angeles.

PANORAMA

he spent long hours in Los Angeles hospitals, watching operations and observing doctors in their daily rounds.

Moser's careful attention to detail paid good dividends: After Los Angeles physicians had seen his pilot film on leukemia in pregnancy, they gave the whole series their official endorsement. The program also seems to have gained the full confidence of the National Broadcasting Company: The network is running "Medic" at an hour when its chief competitor is C.B.S.' formidably popular "I Love Lucy."

'Pernicious' Prescribing

"Prescribing cooperatives" are mushrooming in several parts of the country, and drug manufacturers are becoming concerned about them. Recently they announced that their National Pharmaceutical Council would do all in its power to persuade doctors and druggists to steer clear of such outfits.

How do Rx cooperatives work? Quite simply, says Dr. Theodore G. Klumpp, president of the Council:

A group of doctors and druggists get together to form a corporation. The corporation then produces drug products that are imitations, as a rule, of leading brands. The physician-members of the cooperative prescribe these drugs to their patients and the pharmacists sell them. Both doctors and druggists share in the profits.

Pointing out that such co-ops have proved especially profitable in the South, Dr. Klumpp tells of one company that has taken in forty new doctors in the past year. But, profitable or not, he concludes, the practice is a "pernicious" one; it violates the ethics of both professions; and it ought to be rooted out.

New Grievance Rules

Many a medical society has found that its grievance committee wasn't doing the main job it was set up to do: settle doctor-patient disputes quickly, quietly, and fairly. Recently the Los Angeles medical association made this discovery—and decided to do something about it.

First, the doctors asked them-



RX COOPERATIVES MUST GO,
says Dr. Theodore G. Klumpp.

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selves what was wrong. They agreed that their grievance committee (1) based too many rulings on insufficient evidence, haphazardly gathered, and (2) lacked authority to enforce its rulings, once they were made.

To correct this, they gave the committee several important new powers. In the future, says its chairman, Dr. J. S. Kelsey Jr., the committee will have authority to:

¶ Act as a legally constituted "board of arbitration," whose findings are legally enforceable by either party to the dispute.

¶ Require doctor and patient to appear before the committee at the same time, "so that each is familiar with the statements of the other."

¶ Require both doctor and patient



REPUBLICANS IGNORE M.D.s,
charges Dr. Frank E. Wilson.

to testify under oath, with discussion limited to "matters germane to the complaint."

¶ Obtain the patient's credit rating in all cases where the disputed fee is \$100 or more.

¶ Obtain the doctor's "case histories and essential reports" whenever necessary.

These new powers, Dr. Kelsey says, will make it possible for the grievance committee "to render [more] just and equitable decisions."



GRIEVANCE BOARD WITH BITE
is headed by Dr. J. S. Kelsey Jr.

'Lobbyist' Sums Up

Whatever happened to the "new era of teamwork" between Government and medicine—an era foreseen when the 1952 election returns rolled in? Dr. Frank E. Wilson, head of the

PANORAMA

A.M.A.'s Washington office, sums up two years of Republican rule in these rueful words:

"Sometimes it's harder to work with your friends than with your enemies."

With Oscar Ewing out of the way, Dr. Wilson had looked forward to smoother sailing. As he put it recently to the Rhode Island Medical Society:

"It seemed to me that [after] twenty years of the closed-door policy, the new Administration would hang a lantern in the window . . . for doctors. I think it is accurate to say that Mr. Eisenhower has done this. But not all the high-ranking officials have followed his lead."

Instead, says Dr. Wilson, "the

canvas curtain" was lowered. At first, holdovers from the old regime were blamed. Now, with their ranks thinned, "things are a little bit different, but the curtain is never out of sight."

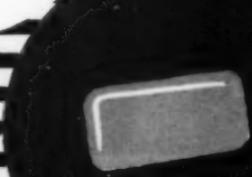
As proof that the profession has been ignored, Wilson cites the fate of the medical advisory committee appointed by Mrs. Oveta Culp Hobby (secretary of the Department of Health, Education, and Welfare) from a list of physicians submitted by the A.M.A.

"She has not once called this committee together," he points out, "in spite of the fact that her own experts sat down and planned for the compulsory inclusion of physicians under Social Security . . . Not a sin-

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gle M.D. other than a Government employee sat in on the several meetings that resulted in this decision."

The Administration's health program, including reinsurance of voluntary health plans, is not something to be forgotten with the end of the last Congress, Dr. Wilson warns: "The parts . . . not passed now will be reintroduced in the next Congress. Even if there is a change in control of Congress . . . the Eisenhower Administration will press for these bills, and there is no question that they would have the support of many, many democrats."

The A.M.A. position on reinsurance ("that we are in accord with the stated objectives, but must oppose the Government's methods of

reaching them as stated in the bill") will be maintained, Dr. Wilson predicts. And he adds:

"Just about every time we oppose a major bill, somebody asks, 'Why does the A.M.A. always oppose everything? Why don't they come forward with an alternative?' The answer lies in the fact that the A.M.A. is one of the few national organizations which does not ask favors from Congress and wants no Federal money.

"A more succinct explanation was given to me the other day. I was told that nine of the Ten Commandments start out with 'Thou shalt not . . .' One of them says, 'Thou shalt not commit adultery' . . . The Bible does not suggest an alternative." [MORE→

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[†]Seigler, E. J.: Geriatric Medicine, ed. 3, Philadelphia, J. B. Lippincott Company, 1954, p. 21.

Dr. Wilson's final sum-up:

"There has been a change in the Federal Government in its attitude toward health. The present Administration is honest in its motives, but a little too desirous of pleasing everybody, including those who have been so well pleased for twenty years."

Dim Future for Surgeons?

The future holds plenty of opportunity for psychiatrists, but very little for surgeons. That, at least, is the prediction of James Howard Means.

A rash forecast? Perhaps, concedes Dr. Means, a retired professor of clinical medicine at Harvard.

But he believes that "as surgery gets better and better, there will be less and less of it to do." At the same time, he holds, "our confused and frustrated world" will have an ever-increasing need for "well trained, broadly educated, wisely balanced psychiatrists."

Dr. Means musters some evidence in support of his prediction for surgeons: "Gone already are the wholesale tonsillectomies and mastoid operations which were the stock in trade of the ear, nose, and throat men. Gone is the venereal field of the urologic surgeon. Large- ly gone are the various septic conditions which surgeons used to treat.

"If and when specific cures for cancer are discovered, gone will be



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1. Pensky, N., and Goldberg, N.: New York State J. Med. 53:2238, 1953.
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6. Kalb, C.: To be published.
7. Marshall, W.: M. Times 79:222, 1951.

*Case report.



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another big slice of what the surgeon has had to do . . . Peptic ulcer and ulcerative colitis will slip from his field as the psychiatrist prevents these maladies."

Before too long, Dr. Means claims, the surgeon will have left "only traumatic and plastic surgery and the treatment of congenital anomalies."

Insurance Jokers Hit

After taking volumes of testimony on health and accident insurance, Representative Charles A. Wolverton (R., N.J.) has come up with some pointed warnings about the kind of insurance America doesn't need.

It's peddled to individuals, he says, by "a great many outfits . . . who advertise that their policies provide a get-rich-while-sick bonanza . . . But the small print in their policies takes away just about everything promised in the big print."

Wolverton cites these "gimmicks" in the sort of policies that people are better off without:

¶ Clauses providing benefits for "bodily injuries sustained through accidental means." The gimmick: "If you fell from a ladder while cleaning leaves out of your house gutters and broke your neck, the company could claim that the *means* of injury was not accidental—that you deliberately climbed the ladder . . . Better that the clause read that benefits will be paid for 'accidental bodily injuries.' Legally, that means exactly what you think." [MORE→]



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¶ Clauses defining total disability as "inability to engage in any occupation or employment for remuneration, wage, or profit." The word "any" is the joker. "That means if you cannot do your chosen job . . . but can earn a few dollars doing something else—such as making hooked rugs—then you are not likely to collect insurance." You're safeguarded, though, if total disability is defined as "inability of the insured to engage in his occupation."

¶ Clauses making sickness benefits dependent upon your being confined indoors. Suppose you've had a serious operation requiring weeks of convalescence. "You could lose your benefits if you spend any part of that convalescence sitting on your front

porch, basking in the sun on the hospital grounds, or motoring through your favorite park."

Wolverton's hottest fire is reserved for companies that make a practice of canceling policies as soon as benefits are claimed. "Upward of 90 per cent of non-group, individual health insurance policies sold today can be cancelled by the insuring company—sometimes at once; frequently when the insured's next premium is due," he says.

"On file with our committee are a number of letters giving first-hand accounts of such practices. One sadder but wiser Iowan told how he filed a claim with his insurance company after his doctor hospitalized him for diabetes. 'I sure was sur-



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prised how fast they dropped me," he wrote.

"America doesn't need the kind of insurance policy that is cancelled just because the insured becomes ill and eligible to collect benefits. A company which plays that kind of sure-thing game violates the very spirit and purpose of insurance—to provide protection at the time of need, not to take it away."

To avoid such jokers, Wolverton suggests following three rules when buying health and accident insurance:

1. "Choose a reliable company . . . licensed in your own state. That way, you will be protected by your state insurance department."

2. "Avoid policies which give the company the privilege of cancelling at any time. A non-cancellable, guaranteed-renewable policy . . . assures you benefits during long periods of illness or disability."

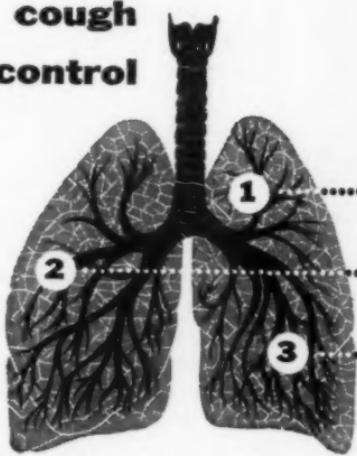
3. "Carefully read [all] the exclusions and exceptions."

Shock Coverage Wanes

Signs are that the risky areas of medicine are becoming still more risky. Shock therapy is a current example. Doctors are finding it harder and harder to get malpractice insurance covering this type of treatment.

Many insurance carriers are now refusing such coverage altogether, claiming it doesn't pay them to provide it. A few companies continue to offer it, but at prohibitive rates—and often only if the doctor agrees to

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pathogens**

Acute infections yield quickly.
Dead bacteria cannot cause
reinfection, become resistant,
cause complications, or spread
infections.

Available in tablets,
pediatric suspension,
and I.V. ampoules.

give the company such of his other insurance business as it may choose to have.

In New York State it's still possible to get insurance for shock therapy through the medical society's group plan. But it isn't available simply on request. The doctor who wants it must make out a separate application, to be reviewed by representatives of the state society. Only if they decide that he is well qualified to do the work, can he take out a policy. He then pays \$75 a year extra for it.

Nation-wide, this type of protection has become so hard to get that the American Psychiatric Association has given up altogether on U.S. insurance companies. It now offers its members shock therapy coverage through Lloyds of London.

1955 Cars Previewed

With auto manufacturers nearly ready to unveil their 1955 models, you may be nearly ready to visit your dealer's showroom. Here's what Ward's Automotive Reports says you can expect to find there:

¶ More models equipped with power steering, power brakes, and high-compression V-8 engines.

¶ An increased use of tubeless tires, to give you more mileage and better protection against punctures.

¶ Radical new body designs—even in the low-priced field. Fords, Chevrolets, Chryslers, De Sotos, Dodges, and Plymouths are all coming out with a new look. [MORE→]

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For a balanced program of parenteral nutrition...

5 new

Travert. 10% Electrolyte

solutions



all the
advantages
of TRAVERT 10%

... twice as many calories as 5% dextrose,
... no equal infusion time, with no increase
in fluid volume ... a greater protein-
sparking action as compared to dextrose
... maintenance of hepatic function

PLUS

replacement of
electrolytes,
and correction
of acidosis
and alkalosis

SOLUTION	ELECTROLYTE SOLUTIONS					
	K	C	NH ₄	Na	Mg	Ca
Modified Dextrose Solution	0.05	0.04	0.03	0.03	-	-
Travert 10% Electrolyte No. 1	0.05	0.10	0.03	0.03	-	-
Travert 10% Electrolyte No. 2	0.10	0.10	0.03	0.03	0.02	-
Travert 10% Electrolyte No. 3	0.05	0.12	0.03	0.03	-	-
Ammonium Chloride 2.14%	-	-	0.02	0.02	-	-
Bunsvor's	0.05	0.04	0.03	0.03	-	-
1/2% Sodium Lactate	0.07	-	0.02	-	-	-
Travert 10% Potassium Chloride 0.7% in Water	-	0.02	0.03	-	-	-
Travert 10% Potassium Chloride 0.7% in 0.45% NaCl	0.05	0.05	0.03	-	-	-
Normal Saline	0.05	-	0.03	-	-	-

milligrams/100 cc. x volume = 10
atomic weight = millimoles/liter

Wallet cards
available on request

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BAXTER LABORATORIES, INC.

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DISTRIBUTED AND AVAILABLE ONLY IN THE 37 STATES EAST OF THE ROCKIES (except in the city of El Paso, Texas) THROUGH
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GENERAL OFFICES • EVANSTON, ILLINOIS

PANORAMA

¶ A greater emphasis on brilliant colors. Reds, whites, bright yellows, even oranges and purples will be featured in many lines.

Prices, apparently, will be unchanged—although some of the smaller companies may make a bid for your business with token cuts. (Studebakers, for example, will cost \$100 less.) But even without official cuts, it'll probably be a buyer's market, with dealers more than willing to come to terms.

Blue Shield Losses

Lost customers are a continuing problem for Blue Shield. According to latest available figures, some local plans are signing up new subscribers

fast—but losing old subscribers even faster. For example:

During the first quarter of this year, Blue Shield plans in Milwaukee and in Omaha lost about five old subscribers for every four new ones enrolled. Plans in Jackson, Miss., and in Charleston, W. Va., reported an even more unfavorable cancellation ratio of six to four.

On a national scale, of course, the Blue Shield plans are still chalking up substantial gains (at least two new subscribers for every one who cancels). But Blue Shield policymakers don't intend to take any chances. In the future, they'll direct more promotional material to old subscribers, concentrate more on the job of keeping them sold. END

Adrenal insufficiency • Collagen diseases • Gout (with colchicine) • Allergic states • Inflammations of the eye • Acute rheumatic fever

Purified Corticotropin Gel (National) is purified ACTH in a repository menstruum (gelatin). Effective for 24 hours or more following subcutaneous or intramuscular injection. Lessens the possibility of producing sensitization.

Supplied: 40 units (clinical activity) per cc., vials of 1 cc. and 5 cc.; 80 units (clinical activity) per cc., vials of 5 cc. ACTH Solution, 20 U.S.P. units per cc.; vials of 2 cc. and 10 cc.

for diseases of **STRESS**

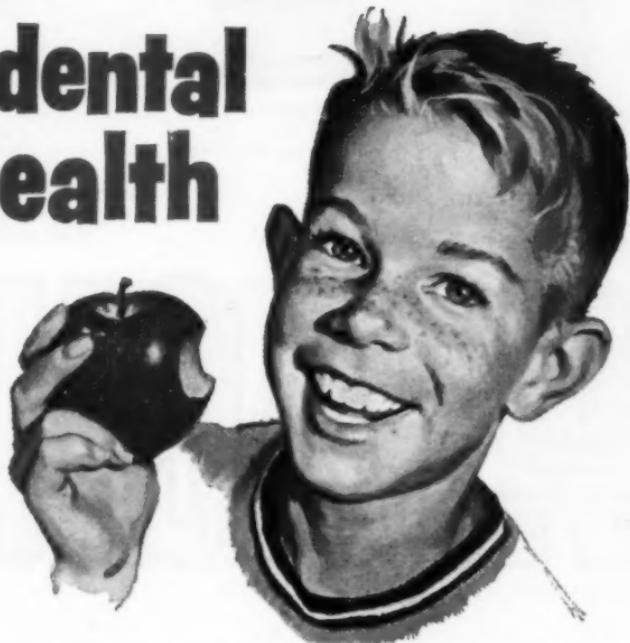


The National Drug Company, 4663 Stenton Avenue, Philadelphia 44, Pa.



PURIFIED CORTICOTROPIN GEL

A delectable aid to dental health



Today's diet, often soft and containing relatively large amounts of carbohydrates, poses a constant threat to teeth and gingivae. A fresh juicy apple after meals is a tasty aid to conservation of dental health. The apple is a succulent cleanser, highly efficacious, convenient and enjoyable. Its firm chewable texture gives needed massage to flabby gums. Its delicate aroma and lively flavor stimulate the salivary glands to copious secretion. These benefits

are provided through regular everyday eating of apples. Your patients will quickly recognize the merits of a recommendation to "eat an apple after meals."

NEW FILM "Gateway to Health" in 16 mm. color and sound. Case histories from practice of Fred D. Miller, D.D.S., Altoona, Pa., demonstrate influence of dietary habits on dental health. Especially suitable for professionally sponsored public education programs. Write to address below.

NATIONAL APPLE INSTITUTE, 726 JACKSON PLACE, N. W., WASHINGTON 6, D. C. In behalf of

THE APPLE GROWERS OF AMERICA

23



OINTMENT (3%)



SPERSOIDS®:

Dispersible Powder

50 mg. per teaspoonful (3.0 Gm.)



ORAL SUSPENSION:
Cherry flavor. 250 mg.
per 5 cc. teaspoonful.



PEDIATRIC DROPS: Cherry flavor
Approx. 25 mg. per 5 drops
Graduated dropper.

INTR
500

ACHRO

now available in these many convenient forms:



OPHTHALMIC
OINTMENT (1%)

TABLETS:
250 mg., 100 mg., 50 mg.



CAPSULES: 250 mg., 100 mg., 50 mg.



INTRAVENOUS:

500 mg., 250 mg., 100 mg.



SOLUBLE TABLETS:
50 mg.

INTRAMUSCULAR: 100 mg. *

ACHROMYCIN

Tetracycline Lederle



EAR SOLUTION (0.5%)

ACHROMYCIN, the new broad-spectrum antibiotic, is now available in a wide range of forms for oral, topical and parenteral use in children and adults. New forms are being prepared as rapidly as research permits.

ACHROMYCIN is definitely less irritating to the gastrointestinal tract. It is more rapidly diffusible in body tissues and fluids. It maintains effective potency for a full 24-hours in solution.

ACHROMYCIN has proved effective against beta hemolytic streptococcal infections, *E. coli*, meningococci, staphylococci, pneumococci and gonococci, acute bronchitis, bronchiolitis, pertussis and the atypical pneumonias, as well as virus-like and mixed infections.

* REG. U. S. PAT. OFF.

50 mg.

LE LABORATORIES DIVISION AMERICAN CYANAMID COMPANY Pearl River, N.Y.



*Still More
Clinical Research
Proving the
Superiority
of*

Roncovite

in anemia therapy —

The rapidly expanding volume of clinical research continues to prove the effectiveness and safety of Roncovite in the common forms of anemia.* These clinical studies of the effect of cobalt-iron have produced gratifying results in several types of anemia.

**AREAS OF
CLINICAL STUDY
INCLUDE:**

- iron deficiency anemia
- anemia in chronic infection
- anemia in pregnancy
- anemia in infants and prematures

Cobalt in therapeutic dosage exerts a specific erythropoietic effect on the bone marrow. Roncovite provides the supplemental iron to meet the need of the resulting accelerated hemoglobin formation.

— and from 1954 clinical reports

"We agree with Waltner (1930) and Virdis (1952) that iron should be given together with cobalt to obtain the most satisfactory results."¹

"Evidence suggests that iron and cobalt provide the most effective hematinic for pregnant women."²

"The babies were closely observed daily for ill effects of the medication while at the premature unit and when they returned for check-ups. None of them showed harmful effects despite the large doses."³

SUPPLIED

RONCOVITE TABLETS

Each enteric coated, red tablet contains:
Cobalt chloride 15 mg.
Ferrous sulfate exsiccated 0.2 Gm.

RONCOVITE DROPS

Each 0.6 cc. (10 drops) provides:
Cobalt chloride 40 mg.
(Cobalt 9.9 mg.)
Ferrous sulfate 75 mg.

RONCOVITE-OB

Each enteric coated, red capsule-shaped tablet contains:
Cobalt chloride 15 mg.
Ferrous sulfate exsiccated 0.2 Gm.
Calcium lactate 0.9 Gm.
Vitamin D 250 units

DOSAGE

One tablet after each meal and at bedtime; 0.6 cc. (10 drops) in water, milk, fruit or vegetable juice once daily for infants and children.

*Bibliography of 192 references available on request.

1. Coles, B.L., and James, U.: The Effect of Cobalt and Iron Salts on the Anemia of Prematurity, Arch. Disease in Childhood 29:85 (1954).
2. Holly, R.G.: The Value of Iron Therapy in Pregnancy, Journal-Lancet 74:211 (June) 1954.
3. Quilligan, J. J., Jr.: Effect of a Cobalt-Iron Mixture on the Anemia of Prematurity, Texas St. J. Med. 50:294 (May) 1954.

Roncovite

The original, clinically proved, cobalt-iron product.

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Have more time  for
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*To relieve surface pain and itch
with greater safety from sensitization*

NEW TRONOTHANE®

HYDROCHLORIDE

(PRAMOXINE HYDROCHLORIDE, ABBOTT)



TRONOTHANE solves the riddle of topical anesthesia with a new approach. Its formula is structurally unique, non-“caine.”

Sensitization and toxicity can be expected to be negligible, judging from their absence in over 1,000 clinical trials to date.^{1, 2, 3, 4}

Yet TRONOTHANE is prompt, effective. Use it to relieve discomfort in episiotomy, hemorrhoids, various itching dermatoses, anogenital pruritus, minor burns, intubation, etc. Write for literature.

Abbott

1. Birnberg, C., and Horner, H., A Simple Method for the Relief of Postpartum Perineal Pain, Amer. J. Obst. & Gynec., 67:661, March, 1954.
2. White, C. J., A New Anesthetic for Certain Diseases of the Skin, J. Lancet, 74:98, March, 1954.
3. Peal, L., and Karp, M., A New Surface Anesthetic Agent: Tronothane, Anesthesiology, in press, 1954.
4. Schwartz, F. R., Tronothane in Common Pruritic Syndromes, Postgrad. Med., 16:19, July, 1954.



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vitamin drop
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are not
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vi-syneral vitamin drops

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only
natural vitamin A
contains these
4 stereoisomers



... vi-syneral vitamin drops

provides

natural vitamin A with all known and fully utilizable active isomers—as compared to synthetic vitamin A which affords only one isomer which requires conversion in the body before it can be utilized in the visual process

natural vitamin D complex for superior protection against rickets as compared, unit for unit, with synthetic vitamin D

anti-convulsant vitamin B₆ (pyridoxine hydrochloride), not present in certain other multivitamin drops.

aqueous* vitamins A and D for far faster and more complete absorption and utilization as compared with oily solutions

no fish oil, no fish taste, no regurgitation.

costs no more, so why not give the greater protection of Vi-Syneral Vitamin Drops (natural vitamins A and D, made aqueous, B complex factors, ascorbic acid).

bottles of 15 cc., 30 cc., and package of 45 cc. (three 15 cc. bottles) with dosage marked droppers.

*Oil-soluble vitamins A and D made water-soluble; protected by U. S. Pat. No. 2,417,299.

SAMPLES from

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Arlington-Funk Laboratories, division
250 E. 43rd Street, New York 17, N. Y.

To Clarify a Major Point....

The recent studies by Grayzel, Heimer and Grayzel, and Sobel and Rosenberg on the absorption and utilization of topical Vitamins A and D were conducted exclusively with

DESTITIN[®] OINTMENT



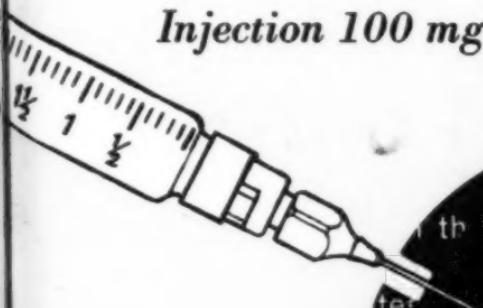
Desitin Chemical Company • 70 Ship Street, Providence 2, R.I.

1. Grayzel, H. G., Heimer, C. B., and Grayzel, R. W.: New York St. J. M 53:2233, 1953.
2. Sobel, A. E. and Rosenberg, A.: 124th Meeting American Chemical Society, 1953.

prevent reactions to penicillin and other parenterals

CHLOR-TRIMETON

Injection 100 mg./cc.



Give an adequate dose.

After giving an adequate dose, inject intramuscularly.

0.1 to 0.2 cc. (10 to 20 mg.)

in the same syringe
with a compatible
aqueous
medication.

Packaging: CHLOR-TRIMETON
Injection 100 mg./cc.,
2 cc. multiple-dose vials.

CHLOR-TRIMETON® Maleate,
brand of chlorprophenpyrid-
amine maleate.

Schering

CHLOR-TRIMETON
Injection 100 mg./cc.

CORICIDIN

...complicated colds

CORICIDIN with Penicillin G

PROCAINE

150,000 units

...simple colds

CORICIDIN

...pain

CORICIDIN with Codeine*

(one 1/2 grain)

CORICIDIN

Each CORICIDIN Tablet contains CITROR[®] TRIMETO[®] Maleate, aspirin, acetophenetidin, and caffeine.

Subject to
Federal Narcotic Regulations.

Schering

Citromax[®] antihistaminic analgesic
antiseptic compound.

XUM

IN URINARY
TRACT
INFECTIONS

FURADANTIN®

brand of nitrofurantoin, Eaton

works this fast

The  first

Furadantin tablet you  give to a patient  produces effective antibacterial concentrations in the urine in

30 minutes 

• 50 and 100 mg. tablets and Furadantin Pediatric Suspension, bottle of 4 fl. oz.



EATON
LABORATORIES
NORWICH, NEW YORK

NOW the safest agent
yet developed for
decisive control of BLOOD PRESSURE
with 5 important firsts

UNITENSE

brand of cryptenamine

Unitense is recommended for the patient who needs more than tranquilizing effects. It produces positive, sustained falls in blood pressure.

This is what Unitense Tablets do . . . and with unparalleled safety

Summary of Case Histories Series A*

Age—Sex	B.P.—mm. Hg. BEFORE	B.P.—mm. Hg. AFTER
58—M	190/125	140/90
57—M	200/130	130/85
46—M	230/140	140/100
46—M	220/140	100/110
41—M	210/140	155/110
49—M	200/120	100/110
52—M	230/130	180/120
44—M	220/130	175/120
46—M	220/120	160/90

These patients experienced sustained control of blood pressure levels over prolonged periods of time.

(Write for complete clinical data, including case histories.)

*Personal communication to Irvin, Weiler & Company.

FIRST IN MAINTAINING DECISIVE BLOOD PRESSURE CONTROL

The sole therapeutic agent in Unitensen Tablets is cryptenamine—a potent blood pressure lowering alkaloid fraction isolated by the research staff of Irwin, Neisler & Company. In the majority of cases (see chart at left), cryptenamine will lower blood pressure decisively, and will control blood pressure at the lower levels for prolonged periods of time.

FIRST IN SAFETY

Unitensen Tablets exert a central action on the blood pressure lowering mechanism. Circulatory equilibrium is not disrupted. Improved circulation and improved work of the heart are often attained, along with the decisive fall in blood pressure.

Unitensen Tablets have no sympatholytic or parasympatholytic action. Ganglionic blocking does not occur. Unitensen Tablets do not cause postural hypotension and collapse, an ever-present risk with other potent blood pressure lowering drugs. Renal function is not impaired.

FIRST WITH DUAL ASSAY

Unitensen is biologically standardized twice, first for hypotensive response and, second, for side effects (emesis) in the dog so that a safe therapeutic range between the two is assured. In extensive clinical trials only a few isolated cases exhibited occasional vomiting.

Unitensen Tablets do not cause the serious side effects common to widely used synthetic hypotensives. Unitensen Tablets can be given over long periods of time with entire dependability. Cumulative effects have not been noted.

FIRST IN SIMPLE DOSAGE

Start with 2 tablets daily, given immediately after breakfast and at bedtime. If more tablets are needed, include an afternoon dose at 1 or 2 p.m.

FIRST IN ECONOMY

Because of lower dosage, Unitensen Tablets save your patients $\frac{1}{3}$ to $\frac{1}{2}$ over the cost of other potent blood pressure lowering agents.

Each Unitensen Tablet contains: Cryptenamine* 2 mg.†
(as the tannate salt)

*Ester alkaloids of Veratrum viride obtained by an exclusive Irwin-Neisler nonaqueous extraction process. †Equivalent to 260 Carotid Sinus Reflex Units.

IRWIN, NEISLER & COMPANY

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It belongs with your trusted
Johnson & Johnson surgical dressings



You'll find the famous Johnson & Johnson quality in Johnson's Elastic Bandage—Rubber-Reinforced.

Use and prescribe it. You'll like its light weight and extra elasticity. Women like its *natural* flesh color.

And remember—Johnson & Johnson quality costs you and your patients no more.

Johnson's ELASTIC BANDAGE
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S. K. F.'s Remarkable New Drug—

FOR CONTROL OF

SENILE AGITATION

THORAZINE*

'Thorazine' can "change the hostile, agitated, senile patient into a quiet, easily managed patient."
(Winkelman, N. W., Jr.: J.A.M.A. 155:18 [May 1] 1954)

Available in tablets and ampul solution for injection.

Additional information on 'Thorazine' is available on request.

*Smith, Kline & French Laboratories
1530 Spring Garden Street, Philadelphia 1*



*Trademark for chlorpromazine hydrochloride, S.K.F.

he's heard the call for



VI-DAYLIN®

(HOMOGENIZED MIXTURE OF VITAMINS A, D, B₁, B₂, B₆, B₁₂, C AND NICOTINAMIDE, ABBOTT)

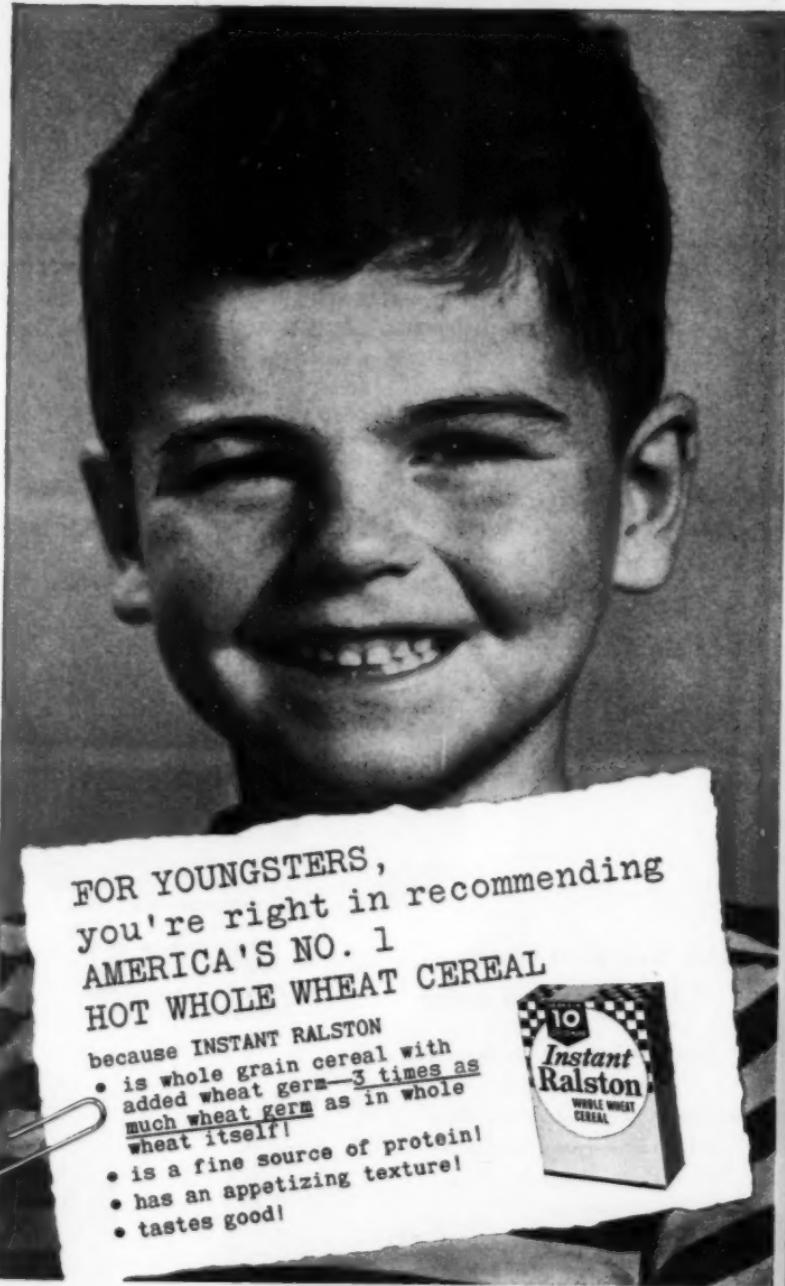
*A full day's serving
of eight important vitamins
(including 3 mcg. of body-building B₁₂)
in each golden spoonful.*

*kids love VI-DAYLIN
right from the spoon*

Delicious lemon-candy flavor and aroma. No pre-mixing, no droppers, no refrigeration. Mixes easily in milk, cereals or juices. Now with B₆ added. In 90-cc., 8-fluidounce and economical one-pint bottles. **Abbott**

Each 5-cc. teaspoonful of VI-DAYLIN contains:

Vitamin A . . .	3000 U.S.P. units
Vitamin B . . .	800 U.S.P. units
Thiamine Hydrochloride . .	1.5 mg.
Riboflavin	1.2 mg.
Pyridoxine Hydrochloride .	0.5 mg.
Ascorbic Acid	40 mg.
Vitamin B ₁₂	3 mcg.
Nicotinamide	10 mg.



FOR YOUNGSTERS,
you're right in recommending
AMERICA'S NO. 1
HOT WHOLE WHEAT CEREAL

because INSTANT RALSTON

- is whole grain cereal with added wheat germ—3 times as much wheat germ as in whole wheat itself!
- is a fine source of protein!
- has an appetizing texture!
- tastes good!



NOW...

THERAPY IN DEPTH



in angina pectoris... status anginosus

PENTOXYLON—combining the tranquilizing, stress-relieving, bradycrotic effects of Rauwiloid and the prolonged coronary vasodilating effect of pentaerythritol tetranitrate (PETN)—provides a completeness of treatment heretofore unavailable to angina patients.

Therapy in depth—for the first time encompasses effective treatment for cause-and-effect mechanisms, which goes deeper than the superficial plane of relief afforded by simple coronary vasodilatation.

Continued therapy with Pentoxylon can be expected to reduce markedly or abolish nitroglycerin requirements, and greatly relieve the apprehension of the patient who lives in dread of the next attack.

Each long-acting tablet of Pentoxylon contains pentaerythritol tetranitrate (PETN) 10 mg. and Rauwiloid 1 mg.

Dosage: 1 to 2 tablets q.i.d. Available in bottles of 100 tablets.

- Reduces nitroglycerin needs
 - Reduces severity of attacks
 - Reduces incidence of attacks
 - Increases exercise tolerance
 - Reduces tachycardia
 - Reduces anxiety, allays apprehension
 - Lowers blood pressure in hypertensives
 - Does not lower blood pressure in normotensives
 - Produces objective improvement demonstrable by EKG.
- Descriptive brochure on request.

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Another **Riker** Original

RIKER LABORATORIES, INC., LOS ANGELES 48, CALIFORNIA

PEDIATRICS

Prepared In The Interests Of The Profession By The Pediatrics Consultant Staff Of H. J. Heinz Company

BULLETIN

HYDROCEPHALUS

AFTER MANY ATTEMPTS over many years to find a cure for this ancient and monstrous deformity, some success has now resulted from a surgical program in which one kidney is sacrificed to enable its ureter to drain the spinal canal into the bladder.

• Although this radical procedure is no simple cure, and too little time has passed for us to be certain in our evaluation of the ultimate success of the procedure, the greatest urgency now appears warranted in making an early diagnosis before brain damage occurs.

• Since we know that mild hydrocephalus can correct itself, attempts at early diagnosis may actually lead

toward unnecessary operations. The most important information available to aid us in making an early and accurate diagnosis of continuing excessive accumulation of spinal fluid results from the simple routine measurement of the greatest circumference of the infant's skull.

• Normal head measurements for different ages are, of course, well established: the head grows about half an inch a month the first five months and a quarter-inch a month for the rest of the first year.

• Because of the possibilities offered by surgery in the cure of hydrocephalus, it is now more important than ever that routine measurements of all babies' heads should be made and recorded during the frequent examinations most babies require for good health supervision.

NOTE: These bulletins are designed to help disseminate modern pediatrics knowledge to the general medical profession and will appear monthly in Medical Economics.



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Symbol Of Fine Quality Since 1869



Heinz Baby Foods And Heinz Baby Food Advertising Are Reviewed And Accepted By The Council On Foods And Nutrition

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*T. M. Reg. U. S. Pat. Off.



PAIN HAS TWO ASPECTS. WHY TREAT ONLY ONE?



Pain has two aspects—physical and psychic. Most analgesics, however, treat only physical pain. But as Krantz and Carr point out: ". . . the emotional trauma produced by the pain is an essential segment of the pain syndrome which must be treated."¹

'Daprisal' does just that. 'Daprisal' relieves the psychic aspects of pain because it contains the components of Dexamyl*—S.K.F.'s widely prescribed mood-ameliorating preparation.

'Daprisal' also relieves physical pain because it provides the combined analgesic effect of acetylsalicylic acid and phenacetin—potentiated by amobarbital.

DAPRISAL*

for the relief of pain and the mental and emotional distress that prolongs and intensifies pain

Smith, Kline & French Laboratories, Philadelphia

1. Krantz, J. C., and Carr, C. J.: Pharmacologic Principles of Medical Practice, Baltimore, Williams & Wilkins Co., 1951, p. 587.

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oral
estrogen-progesterone
effective in
menstrual disturbances:

Each scored tablet contains:

Estrogenic Substances* . . 1 mg.
(10,000 I.U.)

Progesterone 30 mg.

*Naturally occurring equine estrogens (consisting primarily of estrone, with small amounts of equulin and equilenin, and possible traces of estradiol) physiologically equivalent to 1 mg. of estrone.

Available in bottles of 15 tablets.

The Upjohn Company, Kalamazoo, Michigan



Cyclogesterin
TRADEMARK, REG. U.S. PAT. OFF.
tablets

XUM

Letters

Specialists vs. G.P.s • Is the influ-

encing of medical legislation democratic? • Crowded reception
rooms don't impress patient • Free choice hailed

New Doctor Crop

SIRS: After perusing the results of your survey of the 1954 doctor crop—well, may I offer my congratulations to what seems a remarkably gutless, lazy, and incompetent group of young men? These fledgling M.D.s apparently believe that the diploma should guarantee them an assured, easy practice (no night or house calls, please).

To these poor, deluded graduates, I now offer a quick summary of my own recent past:

After two years of residency, I was forced by economic pressure into G.P. work in a rural area. Then a shattered right leg cost me that practice and eleven months of work. It's taken me two years in a new location to pay off my debts. Now I can finally start saving for my last year of residency and a third starting practice.

And I'm not bitter. I'm grateful that I'm as well off as I am.

A. W. White Jr., M.D.
Houston, Tex.

SIRS: As a young physician who graduated cum laude from medical

school, I'd like to comment on the difficulty of getting ahead.

Many of us made the stupid mistake of getting married and having a family. Now we find it next to impossible to complete a residency without sponging on our relatives. In most hospitals, janitors are paid far better than internes and residents. The system is archaic, unjust, and degrading!

No wonder that medicine, as your magazine reports, is attracting fewer and fewer "A" students.

M.D., New York

The G.P.s Answer

SIRS: You devoted a recent news item to pediatrician James Root's charge that G.P.s don't practice good preventive medicine. We family doctors lack the "training, time, and interest," according to Dr. Root.

Allow me to speak out for those who do try to prevent disease. We try—but we have to contend with John Q. Public himself.

In my prosperous farming community, for example, few patients are willing to pay for a complete work-up on their first visit. Let's

LETTERS

face it: They'll accept the high cost of good preventive care—if the bill comes from a specialist. But not from a general practitioner.

J. E. Perez, M.D.
Salinas, Calif.

Sirs: It would seem that pediatrician Root considers the average G.P. to be little more than a charlatan. I'd like to remind him that the average *pediatrician* is a G.P. who limits his practice to children.

Yale Gordon, M.D.
Elmwood, Conn.

Less Talk Urged

Sirs: For years I've watched our forests being depleted of lumber to make paper for printing asinine articles on the evils of fee splitting, on hospital accreditation, on the G.P. vs. the specialist, etc.

While we continue this verbal diarrhea, our shrewd cultist friends move steadily ahead. And all we accomplish is to show our black eyes to the public.

Isn't it time for doctors to become constructive for the good of the patient, not just notorious for the good of the lay press? For instance, let specialists and G.P.s work together, not bicker; they're *both* valuable and necessary.

E. D. Urban, M.D.
Sikeston, Mo.

Fewer Specialists Urged

Sirs: We general practitioners have no quarrel with the *true* specialists: We need them, look up to them,

and couldn't get along without them.

But sometimes, for lack of the real thing, we must refer our patients to men who have forsaken the ideals of the profession by grabbing patients, running down their competitors (especially G.P.s), and going after the fast buck.

It's these men—not the real specialists—who are the chief offenders and who have brought down on our heads the charges of unnecessary surgery, high fees, and fee splitting.

Arthur A. Mickel, M.D.
Cassville, Mo.

Influencing Legislation

Sirs: A recent MEDICAL ECONOMICS editorial suggests that the democratic process was operative in causing the House Ways and Means Committee to vote down Social Security for physicians. You mention that telegrams and letters from local medical societies were important influences on the vote.

If my upstate New York county society is any criterion, the adjective "democratic" is highly inappropriate for what really happened.

The chairman of our legislative committee, upon receipt of a communication from the A.M.A. Washington office, promptly sent our Congressman a telegram protesting Social Security coverage. By implication, he spoke for the whole society. But no vote was taken; and we have no record of the actual feeling

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for individualized control of tension peaks

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...without overdrugging

Nidar is the first agent developed exclusively to control the tensions of modern living *when they occur.*

In ordinary life situations, tensions occur in daily peaks; they are not continuous. This was fully realized when Nidar was formulated. In contrast to other agents, the action of Nidar is neither too short nor too long. It is neither too potent nor too weak. Nidar controls tensions *when they occur.*

RAPID ONSET...action of Nidar will be noticed in about 20 minutes. ADDITIVE ACTION...tension control rapidly becomes more pronounced. LENGTH OF ACTION...the sedative effect of Nidar lasts only from 4 to 5 hours.

Each light green scored Nidar tablet contains:

Secobarbital Sodium $\frac{1}{2}$ gr.
Pentobarbital Sodium $\frac{1}{2}$ gr.
Butabarbital Sodium $\frac{1}{2}$ gr.
Phenobarbital $\frac{1}{2}$ gr.

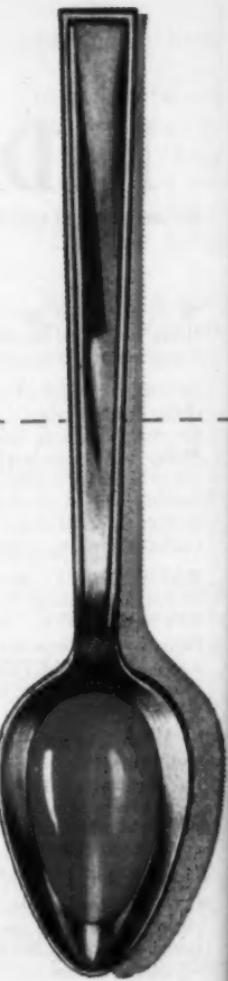
Bottles of 100 and 1000.

One tablet about $\frac{1}{2}$ hour before the period of morning tension and another tablet about $\frac{1}{2}$ hour before the period of afternoon tension. At night, 1 or 2 tablets before retiring.



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—a delicious pink, creamy, coconut-custard flavored suspension of the ideal oral penicillin, potassium penicillin G, which will maintain its penicillin potency for two years without refrigeration.

DRAMCILLIN**DOSAGE****FORMS:**

Drumcillin-300 Suspension 300,000 units* per teaspoonful (5 cc.)

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Drumcillin 100,000 units* per teaspoonful

Drumcillin-500 500,000 units* per teaspoonful

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Drumcillin with Triple Sulfonamides

Drumcillin-250 with Triple Sulfonamides

Drumcillin-250 Tablets with Triple Sulfonamides

*Buffered crystalline potassium penicillin G.

WHITE LABORATORIES, INC., Kentwood, N. J.

LETTERS

of our members in this matter. The same sort of thing has happened several times before.

Do most county medical societies influence legislation in this way? If so, how democratic is our influence?

M.D., New York

What Women Want

Sirs: We've been hearing a lot about the nurse shortage. I maintain that one reason why many young women avoid the profession is that it offers too few social opportunities.

Should a girl go to college, or should she enter nursing? College offers her, along with other social contacts, a reasonably good chance to find a husband. Schools of nursing provide few social advantages—

and many of them discourage marriage.

Everyone would benefit if the teaching of nursing were transplanted to the college campus. Local hospitals could be utilized for practical experience; and the final year could take the form of a nursing internship.

Bruce M. Burdick, M.D.
Los Angeles, Calif.

Salaried Practice

Sirs: You recently reported decisions in Colorado and Iowa that brand as unethical any service to a hospital by a specialist on a salaried basis.

Isn't this a scheme to compel all community hospitals to replace

Prescribed by physicians throughout the world

Have **YOU** ever
used

FELSOL provides safe and
effective relief in *Asthma, Hay Fever*
and related bronchial affections.

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The fast action and long duration of FELSOL gives smooth and comforting relief. After a single therapeutic dose of antipyrine, Brodie and Axelrod report, "Plasma levels declined slowly, measurable amounts of the drug persisting 24 hrs." (J. Pharm. & Exper. Ther. 98:97-104, 1950)

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MEDICAL ECONOMICS • OCTOBER 1954

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sedation without hypnosis

R Serpasil

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A pure crystalline alkaloid of rauwolfia root
first identified, purified and introduced by CIBA

In anxiety, tension, nervousness and mild to severe neuroses—as well as in hypertension—SERPASIL provides a nonsoporific tranquilizing effect and a sense of well-being. Tablets, 0.25 mg. (scored) and 0.1 mg.

C I B A
SUMMIT, N. J.

5/1960

Rauwolfia serpentina

AS SOLE THERAPY

**For every patient with mild,
moderate, or labile hypertension**

In addition to dropping the blood pressure moderately, *Rauwolfia serpentina* produces marked, often dramatic, subjective improvement. It relaxes the emotionally tense patient, inducing a welcome state of calm tranquility. Headache, tinnitus

and dizziness are greatly relieved, and the discomfort of palpitation is usually overcome. Hence, it usually suffices as sole medication in mild, moderate and labile hypertension, especially when the emotional element is a prominent factor.

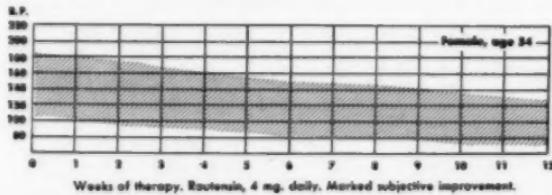
Rautensin

Purified *Rauwolfia Serpentina* Alkaloids

Rautensin produces the typical hypotensive, sedative, and bradycrotic effects characteristic of this important new drug. Each tablet contains 2 mg. of the alseroxylon fraction, a highly purified alkaloidal extract entirely free of inert material. The alseroxylon fraction is tested in dogs

for its ability to lower blood pressure, produce sedation, slow the pulse.

The initial dose of Rautensin is 2 tablets (4 mg.) daily for 30 days. Thereafter, the intake is dropped to 1 tablet (2 mg.) daily. Side actions are rare and there are no known contraindications.



SMITH-DORSEY • Lincoln, Nebraska A Division of THE WANDER COMPANY

Rauwolfia serpentina

IN COMBINATION

For the patient with chronic, severe, or fixed hypertension

Most cardiologists today assert that in severe or fixed essential hypertension, combination therapy is more efficacious than any single drug alone. The combination of *Rauwolfia serpentina* and *Veratrum viride* is

especially favored since it results in an additive, if not a synergistic, effect. In this combination, the dosage requirements of veratrum are reduced, hence the incidence of side effects is minimized.

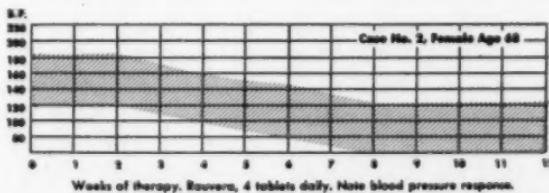
Rauvera

Rauwolfia Serpentina and *Veratrum Viride* Alkaloids

Each Rauvera tablet combines 1 mg. of the alseroxylon fraction of *Rauwolfia serpentina* and 3 mg. of alkavervir, a highly purified alkaloidal extract of *Veratrum viride*. The potent hypotensive action of veratrum is thus superimposed on the desirable influence of *Rauwolfia*.

Rauvera leads to a substantial reduction in blood pressure and marked subjective improvement, hence produces excellent results in chronic, severe, and fixed hypertension.

The average dose of Rauvera is 1 tablet 3 times daily, after meals, at intervals of no less than 4 hours.



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LETTERS

M.D.-superintendents with laymen? Sounds like it to me.

Another thing: Must Colorado and Iowa now scrap their state hospitals and TB sanitaria? And what happens to medical officers working in Army institutions? I hope *some* loophole was left for such cases.

M.D., Virginia

Doctors Aren't Beasts

Sirs: I heartily disagree with the doctor's wife who recently complained in your pages about her sad lot. Does she honestly believe that any woman entering matrimony with an M.D. must give up all right to life, liberty, and the pursuit of happiness?

True, a doctor's wife must often be lonely. But that's no reason for bemoaning her fate. When the doctor's not home, she can prepare and create things they both enjoy for the times when they *are* together.

If the choice were put to me again, I'd still want to marry a medical man.

Helen S. Foster
San Francisco, Calif.

Draft Assurances

Sirs: In a recent letter to MEDICAL ECONOMICS, Dr. B. A. Maranville II complains of the present draft set-up. He reports that he and other draft-eligible internes have trouble getting residencies "because everyone knows we'll soon be called to active duty—but no one knows when."

Let Dr. Maranville be assured that we in the Department of Defense are seeking in every way to overcome this problem. Specifically, we hope that our so-called "Matching Plan" will help. The services themselves are cooperating by apprising us well in advance of the number of doctors they'll need during a given period.

Finally, I've requested the hospitals to help us by trying to provide even very abbreviated periods of residency training for post-internes who are awaiting the call to military service.

Frank B. Berry, M.D.
Washington, D.C.

Dr. BERRY is Assistant Secretary of Defense for Health and Medicine.

Not Impressed

Sirs: Why is it that so many doctors seem to have a complete disregard for the value of their patients' time?

Do they *really* labor under the misapprehension that a crowded office impresses us? If only they knew that most of us patients look on such doctors merely as bad managers!

Eleanor G. Hauser
Scarsdale, N.Y.

Age on Rx Blanks

Sirs: In listing the steps we must take to comply with state and Federal narcotic laws, you said nothing about including the patient's *age* on a prescription blank. This is a legal requirement in my state. But I think it's a good idea to specify age even in states where it isn't required. This

Combination tranquilizer-antihypertensive

*especially for
moderate and severe
essential hypertension*

Serpasil-Apresoline®

hydrochloride

(RESERPINE AND HYDRALAZINE HYDROCHLORIDE CIBA)

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- The more marked antihypertensive effect of Apresoline and its capacity to increase renal plasma flow.

*Each tablet (scored) contains 0.2 mg.
of Serpasil and 50 mg. of Apresoline
hydrochloride.*

C I B A
SUMMIT, N. J.

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LETTERS

serves as one more precaution against possible malpractice suits: It proves you knew whether or not your patient was a minor.

M.D., Massachusetts

Second Degree

SIRS: In your recent discussion of business stationery, you said that premedical degrees like B.A. and B.S. don't belong on a doctor's letterhead.

I think you're wrong. I include a B.S. in my letterhead. I feel that the holder of a premedical degree is just as entitled to have it appear on his stationery as any "fellow" in any "college" is entitled to use those symbols.

As a matter of fact, he's *more* en-

titled to publicize it, since the premedical degree comes from a genuine institution of higher learning. The specialty colleges, on the other hand, aren't really colleges at all. They're professional organizations much like trade unions.

Richard H. Sherwood, M.D.
Buffalo, N.Y.

Freedom of Choice

SIRS: You quote Dr. E. M. Bluestone of New York as having said that the practice of good medicine is "not necessarily dependent" on the patient's right to select his own doctor. I not only disagree violently; I can't help wondering how any reputable physician can possibly reject the principle of free choice. [MORE→

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ferrous sulfate, U.S.P. 1.05 gm.
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(containing intrinsic factor)

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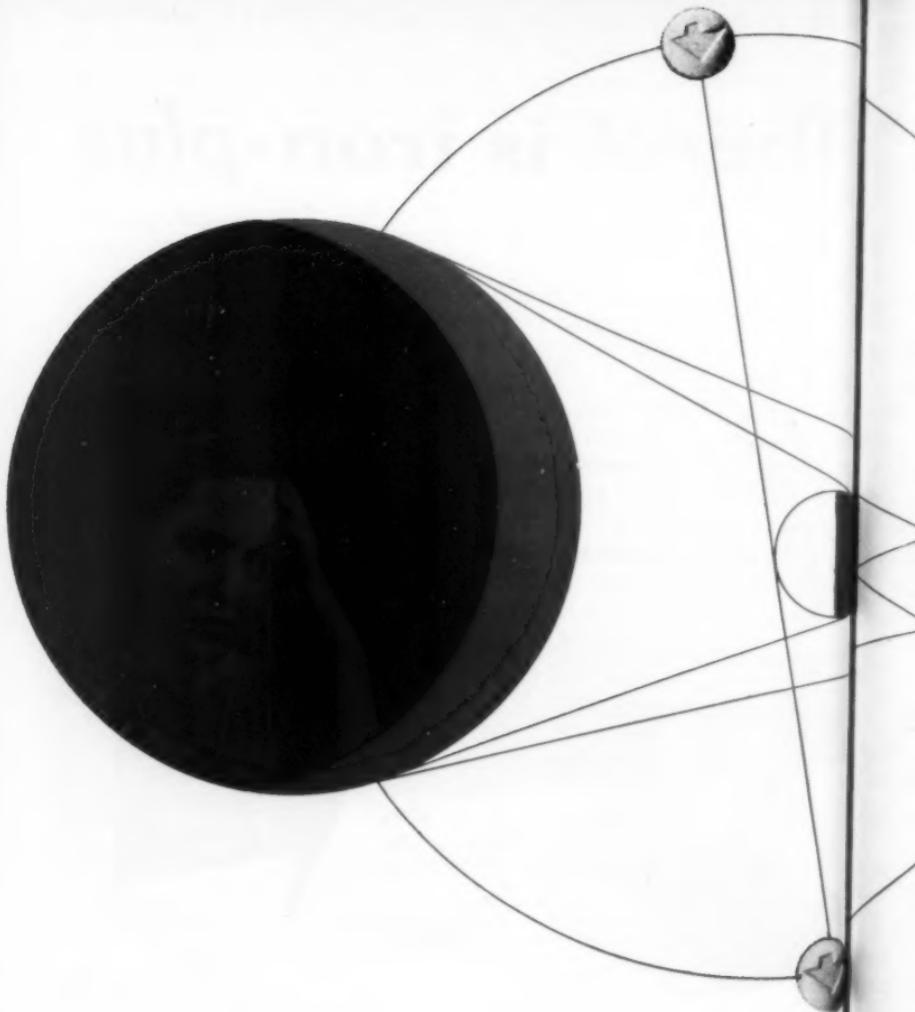
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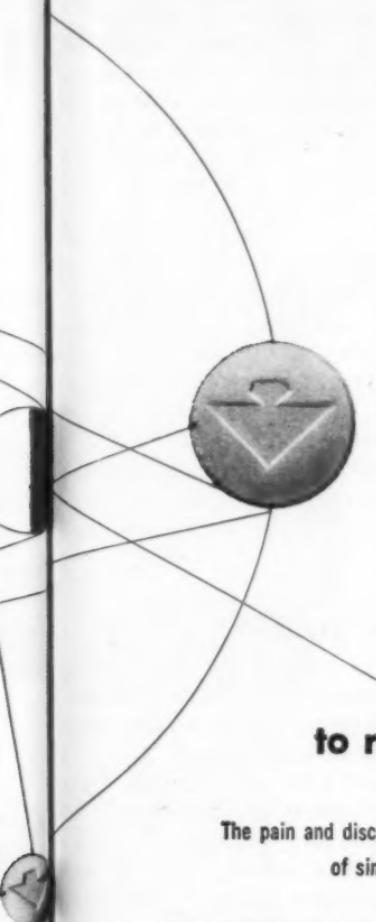


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This dependable APC formula is fast-acting and continues its analgesic effect over prolonged periods of time.

Anacin provides mild sedation — patient tolerance is excellent.

Consider Anacin for your patients.



Whitehall Pharmacal Company, New York 16, N. Y.

LETTERS

It seems to me that only four types of medical men would be likely to share Dr. Bluestone's opinion:

1. The physician who has been unable to build up a practice. In self-defense, he yearns for a system in which patients *must* be sent to him.

2. The man who longs for a job with regular hours and no personal responsibility. This man will settle for a fixed salary, assigned patients, and perhaps a title for prestige purposes (Professor, Chief, etc.).

3. The doctor who does experimental work. He needs large groups of patients to "try things" on. He finds them, of course, among people who have no personal doctor to look after them.

4. The out-and-out radical, who wants to destroy the personal relationship in medicine, as well as in everything else.

M.D., New York

SIRS: I have great regard for Dr. Bluestone. He is one of the brilliant thinkers in hospital administration. But he is also an outspoken proponent of the Montefiore Home Care Plan, whereby Montefiore—a private, voluntary hospital—practices corporate medicine through its salaried physicians. Any such plan, of course, eliminates free choice.

I can conceive of calling a strange plumber or picking a garage man at random *in an emergency*. But when time permits, I prefer to choose my own plumber or mechanic. So, too,

I prefer to choose my own lawyer, my own dentist, my own doctor.

I hold this to be my inalienable right. To say that it's unnecessary or undesirable is to go against all that clear-thinking citizens hold dear.

Edwin Matlin, M.D.
Mt. Holly Springs, Pa.

SIRS: In the U.S.A., doctors value their personal freedom. We would resent being assigned to certain patients and being forced to come when they whistle—as doctors must sometimes do in countries like England.

Anyone who advocates an end to free choice has obviously forgotten this fact.

G. W. Montgomery, M.D.
Caldwell, Idaho

Name Trouble

SIRS: I feel slighted at not having been mentioned in an item you published recently about doctors whose names are much too apt. I've been plagued with "name trouble" ever since I entered medical school.

When I was at Tulane, there were three of us suffering together: myself, a student named Slaughter, and a teacher in the surgery department named Graves. Whenever some local newspaper columnist ran out of material, he could be depended on to call attention to this gruesome sounding trio.

Andrew S. Tomb Jr., M.D.
Victoria, Tex.
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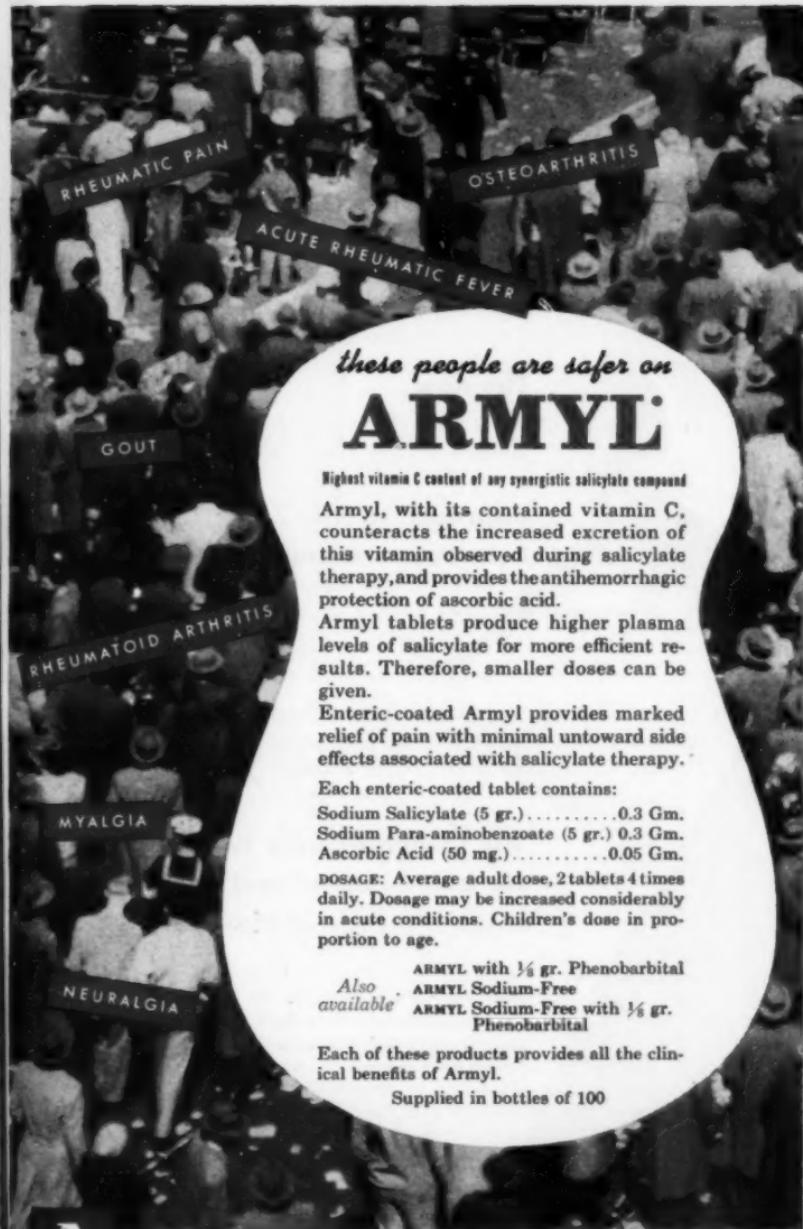
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these people are safer on
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Highest vitamin C content of any synergistic salicylate compound

Armyl, with its contained vitamin C, counteracts the increased excretion of this vitamin observed during salicylate therapy, and provides the antihemorrhagic protection of ascorbic acid.

Armyl tablets produce higher plasma levels of salicylate for more efficient results. Therefore, smaller doses can be given.

Enteric-coated Armyl provides marked relief of pain with minimal untoward side effects associated with salicylate therapy.

Each enteric-coated tablet contains:

Sodium Salicylate (5 gr.) 0.3 Gm.
Sodium Para-aminobenzoate (5 gr.) 0.3 Gm.

Ascorbic Acid (50 mg.) 0.05 Gm.

DOSAGE: Average adult dose, 2 tablets 4 times daily. Dosage may be increased considerably in acute conditions. Children's dose in proportion to age.

ARMYL with $\frac{1}{2}$ gr. Phenobarbital

Also available **ARMYL Sodium-Free**
ARMYL Sodium-Free with $\frac{1}{2}$ gr.
Phenobarbital

Each of these products provides all the clinical benefits of Armyl.

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XUM

EXPASMUS, a new combination of antispasmodics, plus a powerful analgesic—in single-prescription form—effectively reduces both skeletal and smooth muscle spasm, while affording more rapid release from pain.

Though skeletal muscle pain-spasm often engenders secondary smooth muscle spasm, no single antispasmodic preparation free of belladonna, barbiturates or amphetamine has heretofore been formulated to treat both types of spasm. In this respect, Expasmus is unique...as it combines dibenzyl succinate and mephenesin with the powerful analgesic, salicylamide.

As is well known, dibenzyl succinate^{1,2,3,4} relaxes smooth muscles without side effects, and is safe even in large doses. Mephenesin^{5,6,7,8} offers skeletal muscle relaxation and a sedative effect free from the disadvantages of the barbiturates or the possibility of habit formation. The analgesic action of salicylamide^{9,10,11,12} is held to be several times greater than aspirin. These three ingredients have been judiciously combined in Expasmus—to provide safe, fast-acting and comprehensive therapy.

DESCRIPTION: Each tablet of Expasmus contains dibenzyl succinate, 125 mg.; mephenesin, 250 mg.; salicylamide, 100 mg. Expasmus is packed in bottles of 100 tablets. On your prescription only.

INDICATIONS and DOSAGE: For relaxation of skeletal and associated smooth muscle spasm; relief of arthritic and low back pain; as a mild non-barbiturate sedative and relaxant in tension—Average dose, two tablets every four hours. Maximum daily dose, twelve tablets.

REFERENCES: 1. New and Nonofficial Remedies 1930. 2. T. Sollman, "A Manual of Pharmacology" 7th Ed.; W. B. Saunders Co., Philadelphia; 1948. 3. A. Osol & G. E. Farrar, "The Dispensatory of the U. S." 24th Ed.; J. B. Lippincott Co., Philadelphia; 1950. 4. "The British Pharmaceutical Codex" 5th Ed.; The Pharmaceutical Press, London; 1949. 5. R. T. Smith; M. Clin. North America; 33; 1619; 1949. 6. I. F. Herman & R. T. Smith; Journal-Lancet; 71; 271; 1951. 7. L. S. Schian & K. R. Unna; J.A.M.A.; 140; 672; 1949. 8. W. R. Nesbit; Ind. Med. & Surg.; 21; 599; 1952. 9. B. E. Benton; Mon. Farm & Terap.; 58; 21; 1952. 10. A. Kirschstein & E. Kusche; Medizinische Monats.; 3; 181; 1953. 11. E. Lechleitner; Deut. Med. Wochschr.; 76; 1303; 1951. 12. E. R. Hart; J. Phlegy.; 89; 205; 1947.

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with codeine phosphate ¼ gr.

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Thiamine	3.0 mg.
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*I. Lange, K., and Weiner, D.: J.
Invest. Dermat. 12:263 (May) 1949.*

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Serpentina***

Increasing experience continues to show that *Rauwolfia serpentina* is as basic in essential hypertension as digitalis is in congestive heart failure. Furthermore, recent evidence* demonstrates that reserpine possesses the unique antihypertensive, sedative, and bradycrotic properties characteristic of this unusual drug. On the basis of this study, reserpine is regarded by these workers as the chief active principle of *Rauwolfia serpentina*.

Crystoserpine—reserpine, Dorsey—is valuable in all grades of essential hypertension. In the milder forms and in labile hypertension, it usually suffices alone. In the more severe forms, it reduces the amounts required of more potent anti-hypertensive agents.

In addition to lowering blood pressure by central action, Crystoserpine induces a state of calm tranquility. Emotional tension is eased, the outlook improved.

There are no known contraindications to Crystoserpine. Dose, 0.25 mg. to 1.0 mg. daily. Supplied in 0.25 mg. scored tablets.

*

Wilkins, R. W.; Judson, W. E.; Stone, R. W.; Hollander, William; Huckabee, W. E., and Friedman, I. H.: Reserpine in the Treatment of Hypertension: A Note on the Relative Dosage and Effects, *New England J. Med.* 250:477 (March 18) 1954.

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*Spies' Basic Formula**

Provides Vitamin C, Folic Acid, Thiamine,
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*Spies, T. D.: J.A.M.A. 145:66 (Jcn. 13) 1951.

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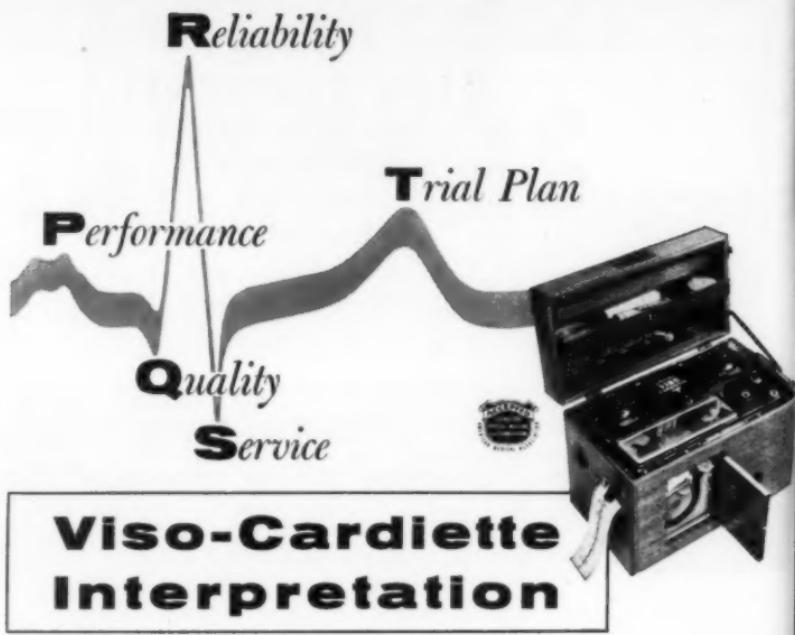
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Recommended dosage: 1 capsule three times daily, or as required. Preferably taken after meals.

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in a single tablet

for moderately severe hypertension

Each tablet contains 1 mg. Rauwiloid and 3 mg.

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Simpler Therapy—Simplified dosage regimen, simplified dosage adjustment, and easier patient management . . . lessened patient supervision.

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"Taste Appeal" for the Low-Fat Low-Cholesterol Diet

Palatability is the key to planning this diet, and these flavor tips will help you keep the "taste appeal" in your patient's diet.

These are for flavor—

Cranberry and tomato sauce pinch-hit for gravy. Fruit juices are to baste with as well as to drink. And herbs and spices lend a fine aroma to all foods.

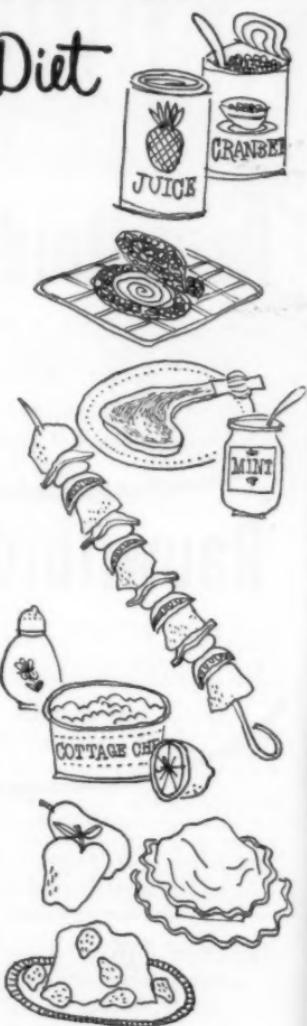
Here's where they go—

Meat loaf can sport a gay cap of whole-cranberry sauce, while "surprise" hamburgers hide a slice of pickle or onion between two thin patties. Your patient can glaze lamb chops with mint jelly. And kabobs add something different.

Most vegetables can be dressed simply with an herb vinegar. On green salads, cottage cheese thinned with lemon juice, sparked with paprika makes the dressing. And on fruits, try lemon juice, honey, and chopped mint.

For dessert, angel cake goes nicely under fruits—skim milk powder makes the "whipped cream." Snow pudding is a simple dessert—fresh fruit, even more so.

These "diet do's" will help keep your patient happy within the limits of the diet you prescribe.



United States Brewers Foundation Beer—America's Beverage of Moderation

Fat—0; Calories 104/8 oz. glass*

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whenever inflammation and infection are co-existing,
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CORTRIL Topical Ointment with TERRAMYCIN offers at once—consistent and effective anti-inflammatory hormonal therapy with CORTRIL—combined with the widely accepted, broad-spectrum antibiotic TERRAMYCIN in an easily applied and specially formulated ointment base.

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Acute infections yield rapidly.

Available in tablets, pediatric suspension, and I.V. ampoules.
Average adult dose: 200 mg. every four to six hours.

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Editorials

About contingent fees in

medicine • How to estimate your earnings • Basic science results • The test of a family doctor • Recall system

Variable Fees

Should fees sometimes be based on results?

Today's trend is away from such fee variations; and there are sound reasons to support the trend—notably, the need for establishing health insurance fee schedules. But it would be a mistake for anyone to think that fees should ever become wholly mechanical, wholly automatic, wholly according to the book.

Suppose a patient consults you about a persistent skin condition. Perhaps he's been to several other doctors, and they haven't helped him. Suppose, through special training or special experience, you are able to clear up his condition. Isn't that service worth more to him than an "average" fee?

The patient himself would almost certainly answer, "Yes"—that is, if his case were handled with appropriate tact.

You can't, of course, set such fees in advance; nor can you surprise the patient subsequently with a whopping bill. What you can do ahead of time is bring up the possibility of

charging what your services actually turn out to be worth.

"My usual fee is x dollars a visit," you might explain, "but you're not a usual case. Perhaps it would be fairer if we delayed establishing the charges until we know the outcome. The total fee might then be somewhat higher than usual, or somewhat lower, depending on results."

Ultimately, if you help such a patient, you're justified in charging a higher-than-average fee. Conversely, if you *don't* help the patient, you're entitled only to minimum compensation.

With most patients, probably, a standard fee should be set in advance. But in special cases, we feel that the fee should be established in the light of the results. You can't guarantee results—no ethical doctor does; but you *can* guarantee to selected patients that they'll at least get their money's worth.

Business Barometer

If you want to estimate whether your own earnings will be higher or lower a few months from now, try

EDITORIALS

asking a few dentists, "How's business?"

Bernard Baruch once called dental practices "the best general economic indicator of all." The reason, of course, is that dentistry is widely regarded as an optional service. People do without dental care when they're hard up for funds. When economic conditions improve, dentists may be the first ones to know it.

Proof of this theory came during the business upturn earlier this year. Politicians were still bewailing the apparent recession; physicians were still reporting a collections lag. But many dentists suddenly noticed that their receipts had begun to climb. And, sure enough, the nation's economy eventually followed.

Right now, dental receipts are booming. But you'd better take another reading—perhaps around the first of the year—before making your income estimates for 1955.

Healer's Yardstick

Nineteen states require that all practitioners of the healing arts pass an examination in the basic sciences (anatomy, pathology, bacteriology, etc.) before they can be given any sort of license. The comparative results tell us a lot about the educational background of today's healers.

Of the medical men who took these examinations last year, 15 per cent failed. This was the best record established by any group. Only one

now 50%
more potent in
antipernicious anemia factor

TRINSICON

(Hematinic Concentrate with Intrinsic Factor, Lilly)

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contains new Vitamin B₁₂ with Intrinsic Factor Concentrate, U.S.P.; plus Special Liver-Stomach Concentrate, Lilly; ferrone sulfate, anhydrous; saccharic acid; and folic acid.

One pint contains 1000 units of therapeutic quantities of all known antipernicious factors.

NEW... VASOCORT*

A safe, effective hydrocortisone preparation to reduce inflammation and edema in the nose

Contains: Hydrocortisone (compound F)—the most effective anti-inflammatory agent—and two vasoconstrictors.

Indications: *Acute, chronic and allergic rhinitis.*

Low hydrocortisone concentration: When applied topically, maximum therapeutic response is achieved with an extremely low concentration of hydrocortisone. Because of its extremely low hydrocortisone concentration (0.02%), 'Vasocort' produces none of the untoward effects associated with systemic hydrocortisone.

Two superior decongestants: Phenylephrine hydrochloride—the most widely prescribed vasoconstrictor—for rapid onset of shrinkage, and Paredrine† Hydrobromide for prolonged shrinkage.

Virtually no rebound turgescence: Because 'Vasocort' contains low concentrations of each vasoconstrictor, it almost never produces rebound turgescence.

Low cost: Despite the fact that 'Vasocort' contains hydrocortisone, it costs your patient no more than other multi-ingredient intranasal preparations.

Available in two forms:

'VASOCORT' SOLUTION and

'VASOCORT' SPRAYPAK*

Smith, Kline & French Laboratories, Philadelphia

*Trademark

†T.M. Reg. U.S. Pat. Off.
for hydroxyamphetamine hydrobromide, S.K.F.

other group came close: the osteopaths, of whom 23 per cent failed.

Among all the "unclassified" healers, 55 per cent proved themselves deficient in basic sciences. Among chiropractors and naturopaths, the failure figure was 60 per cent.

What do these figures suggest? Simply that physicians have the best basic-science backgrounds; that osteopaths aren't far behind; and that no other group deserves serious consideration as well-grounded practitioners of the healing arts.

What's Your Turnover?

One revealing test of any family doctor is the annual turnover among the families under his care. A well-es-

tablished G.P. may lose less than 10 per cent of his clientele a year, including deaths and removals. The figure runs higher, of course, in towns of transient population. But at what point does turnover become a reflection on the doctor?

One possible answer emerges from a recent study in Washington, D.C. "From younger groups questioned," reports Dr. R. Lee Spire, "came the rather startling [findings] that the yearly change in their patient roster ran as high as 60 per cent, with an average of 35 per cent. Such figures would seem to indicate something lacking in the attitude of the younger physicians."

The most satisfying thing about general practice is—or should be—



More time for relaxation . . . more time for patients . . . more time !

The perennial cry of the Doctor has a modern answer. It's simply Histacount Bookkeeping and Filing Systems which cut paper work to a minimum, add systems and order to detail work and keep records "ship shape" . . .

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Especially for stubborn night cough

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EDITORIALS

continuity of care. You see babies born; you watch them grow up; you treat them as longtime friends. Any family doctor who fails to achieve this continuity with at least two-thirds of his patients is probably neglecting the *art* of medicine. It's a sign of failure that shouldn't be obscured by financial success.

Follow-Up System

Most medical men, as we see it, lean backward too far in the matter of reminding patients to visit them for needed follow-up work. In several cases we've heard about recently, patients view this conservatism as just plain lack of interest.

Suppose you have just finished

treating a patient. Suppose his condition warrants another check-up in six months or a year. It's a simple matter, as the patient is leaving, to mention this point and to ask him: "Would you like to have us send you a reminder?"

Almost invariably, in our experience, the patient *wants* to be followed up. And when your secretary later mails him the reminder, she can quite properly say that it's being sent at his own request.

In any event, don't be unduly cautious about instituting follow-ups. They're generally regarded not as "business builders" (which some doctors apparently fear) but as a real service to patients.

—H. SHERIDAN BAKETEL, M.D.

A NEW EXPERIENCE IN

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Rauwidrine™

A COMBINATION OF RAUWILOID[®] 1 mg. AND AMPHETAMINE
SULPHATE 5 mg. IN ONE SLOW-DISSOLVING TABLET

Largely eliminates the cardiac pounding, insomnia, jitteriness engendered when amphetamine alone is used. No barbiturates—no hormones. Relieves depression without leading to excitation.

Riker

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THE AMMORID® WAY**

To relieve common skin irritations accompanied by itching, chafing, or burning, such as prickly heat, intertrigo, and diaper rash; promote rapid healing of excoriations and inhibit secondary infection; and provide an excellent after-bath dressing —

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Contains benzethonium chloride and zinc oxide, in a nongreasy lanolin base. Agreeably scented, easily removed with soap and water or soapless detergents. Supplied in 2-oz. tubes.

To protect against diaper rash—

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A unique product because it combines a special water-softening agent with methylbenzethonium chloride, which inhibits the formation of ammonia by checking the *Bacillus ammoniagenes*, organism responsible for releasing ammonia from urine. Diapers treated "the AMMORID way" are soft and will not chafe baby's sensitive skin.

Supplied in bottles of 240 Gm. of dry powder (enough for 360 diapers).

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0.1 and 0.25 mg. tablets,
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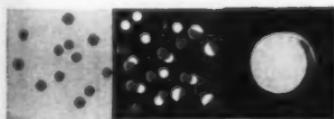
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Literature on request

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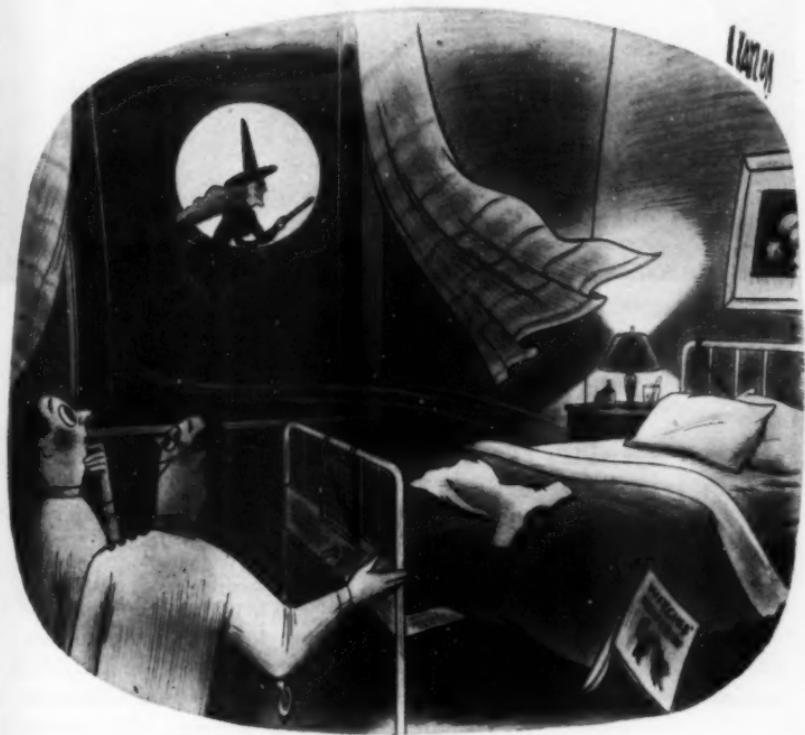
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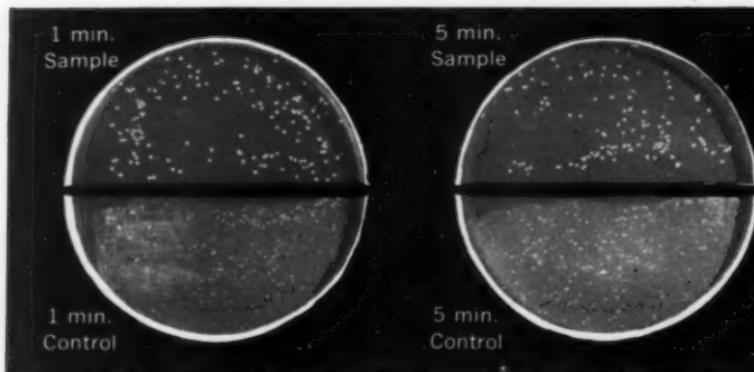
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Photographic evidence of Drilitol's anti-bacterial action against a combined culture of



EXPERIMENT Drilitol's antibacterial agents, gramicidin and polymyxin, were dissolved in 10 cc. diluting fluid. 2 cc. of this solution, which was a much lower concentration of the antibiotics than is provided by 'Drilitol', were combined with 8 cc. of a combined *Hemophilus influenzae*-*Staphylococcus aureus* broth culture.

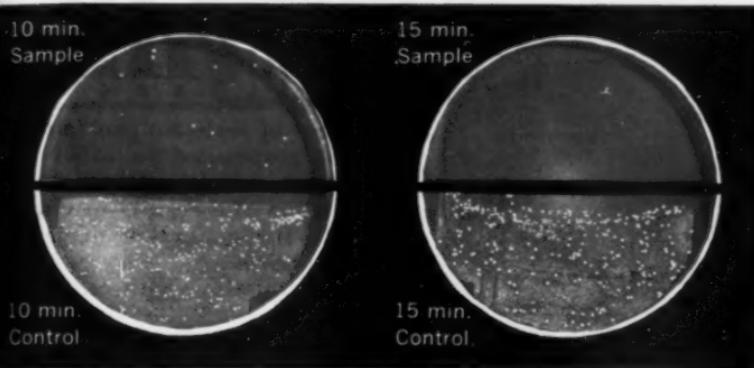
control 2 cc. of the diluting fluid alone were combined with 8 cc. of the *Hemophilus influenzae*-*Staphylococcus* broth culture.

method Samples were taken from each after 1, 5, 10 and 15 minutes respectively, and streaked on chocolate agar. Photographs were taken after the plates were incubated overnight at 37° C.

RESULTS *Hemophilus influenzae*—total bacteriostasis in less than 1 minute.

Staphylococcus aureus—marked bacteriostasis within 15 minutes.

GRAM-POSITIVE STAPHYLOCOCCI AND GRAM-NEGATIVE HEMOPHILUS INFLUENZAE



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1. Two antibiotics—anti-grampositive gramicidin and anti-gramnegative polymyxin.
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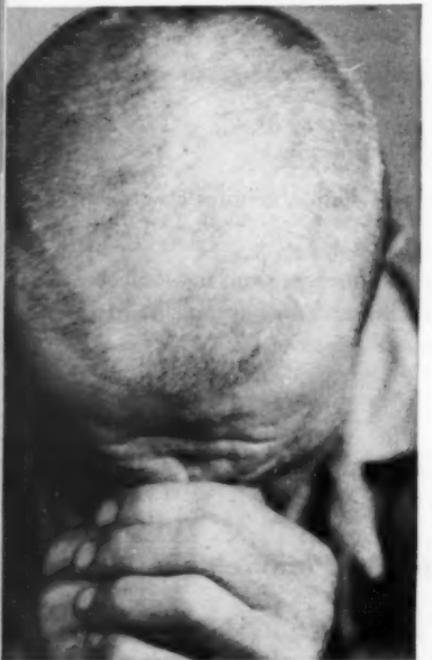
*T.M. Reg. U.S. Pat. Off. for hydroxyamphetamine hydrobromide, S.K.F.

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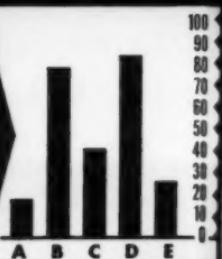


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A series of resistant psoriatics who had not responded to other drugs were treated with RIASOL. The graphs show the results in comparison with the general experience of dermatologists.

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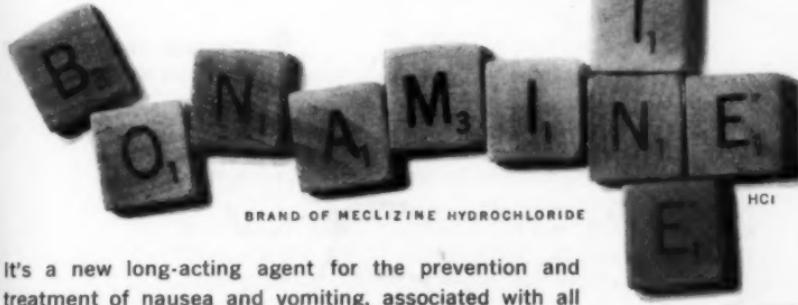
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It's a new long-acting agent for the prevention and treatment of nausea and vomiting, associated with all forms of motion sickness, radiation therapy, vestibular and labyrinthine disturbances, and Ménière's syndrome.

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When Is a Fee Excessive?

The courts have often found this a hard question to answer; but here are some pointers that should help you to judge for yourself

By George I. Swetlow, M.D., LL.B.

- "If you can cure me, Doctor, money's no object."

Perhaps you've had a patient tell you that—and then, after you've restored him to health, refuse to pay your fee. If he termed the fee outrageous and you insisted it was fair, the argument may even have ended in a lawsuit.

I wish I knew of a magic measuring rod that doctors could use for setting incontrovertibly reasonable fees. I don't. But I've seen enough fee cases litigated to be able to pass on some advice that will at least help keep you out of court.

You may know already that prior agreement on a fee is binding. In almost all cases, the patient is required to make good on his promise to pay a certain fee.

The doctor must make good on *his* promise, too. That is, he can't arbitrarily boost his fee, once he's quoted a figure and the patient has accepted it. Even if unforeseen complications arise, he has no legal right to increase a quoted fee, unless the quotation was given with that understanding.

But note this exception to the general rule: A New York surgeon of some eminence did a prostatectomy on an elderly out-patient at an upstate hospital. The patient

DR. SWETLOW, a neuropsychiatrist who turned to law in 1931, is an authority on medical jurisprudence.

WHEN IS A FEE EXCESSIVE?

represented himself as being of modest means, so the doctor agreed to a fee of \$50.

Some months later, the patient died and left an estate of over half a million dollars. The surgeon promptly sued the estate for \$1,000. He won the case. The court held that the doctor had been defrauded by the patient and that the larger fee was entirely appropriate.

In most states, though, the patient's financial status is *not* a legally admissible factor in fee determination. In only a handful of states (e.g., New York, California, Louisiana, Missouri, Pennsylvania, and Washington) have courts held that a physician may properly consider the patient's income when setting the fee. Even there, recognition of the patient's means is considered no license to soak the rich.

Take the case of a California physician who treated a movie star for bronchial pneumonia. The illness was complicated by alcoholism, polyneuritis, and Paget's disease. At the patient's expense, the doctor took an adjoining hospital room and remained in day-and-night attendance for three weeks. Subsequently, the physician submitted a bill for \$12,000—one-twelfth of the actor's annual income.

The movie star balked and was haled into court, where the doctor got a judgment for the full amount of his bill. But a higher court reversed the decision "in view of the very large judgment . . . which must

shock the conscience, until supported by more substantial evidence than now appears in the record."

What "more substantial evidence" was wanted? Not evidence of the patient's means, but evidence of the \$12,000 value set on the doctor's services.

Deciding Factors

Apart from the patient's means, then, what determines whether a doctor's fee is reasonable or excessive? There are four criteria:

1. The nature of the case (difficulty of treatment, duration, number of visits, etc.);
2. The physician's professional standing (size of practice, professional connections, etc.);
3. His training, experience, and skill;
4. The customary charges of physicians of like status for like services.

Unfortunately, there's no mathematical exactness to any of these points. They all leave room for differences of opinion.

For example, take the matter of experience. The courts usually judge this in terms of a doctor's age and time in practice. Not always, though.

It has been ruled in at least one instance that a young physician may be more skillful and learned than an older one who hasn't kept up with medical progress. On this ground, an appellate court overruled a trial court that had cut a young orthopedist's bill for \$1,500 down to \$262,

while allowing a neurology fee of \$1,875 in the same case to a doctor who had been in practice longer.

The fact that a doctor is a specialist does not automatically entitle him to a high fee. The following case bears this out:

A well-known ophthalmologist was testifying for the plaintiff in an accident case. Suddenly the defendant collapsed from a heart attack. The doctor left the witness stand and gave artificial respiration. He continued the treatment for twenty minutes until convinced that it was futile.

The deceased left a large estate; and the ophthalmologist submitted a bill for \$500. The executors rejected the bill as excessive, and the doctor sued.

A medical witness backed up the specialist, testifying to his skill and placing the value of his services at \$500. But doctors testifying for the estate valued his services at only \$15. Their argument: What the doctor had done required no great skill; artificial respiration could have been given even by a medical student.

The \$15 fee was what the ophthalmologist finally settled for.

Sometimes, even when the reasonableness of a bill is not in question, a patient-defendant may forestall a judgment for the physician on such grounds as these:

¶ *Failure of the physician to comply with statutory requirements for admission to practice.*

Some states specify that a doctor

shall register or record his license at the statehouse. If he has inadvertently failed to do so, this may be used as a defense against his action to collect a fee.

¶ *Failure of the doctor to use ordinary skill and care.*

If it can be proved that the treatment didn't measure up to what can reasonably be expected from physicians of similar standing in his community, the doctor will get nothing for his services.

¶ *An understanding between patient and doctor that the latter's services would be given gratis.*

If the physician promises free care, he cannot then successfully sue later for nonpayment. If, for example, an indigent patient comes into a windfall, he may have a moral obligation to pay for previous free services; but he has no legal obligation to do so.

END



"I'm afraid you'll just have to wait. He hasn't been born yet."

The Car You Drive

It's probably a mere Ford (not a Cadillac) and a couple of years old. What's more, most doctors don't prefer sedate black sedans

By Kenneth P. Andrews

- Popular belief has it that the average physician drives a black Cadillac sedan and keeps a spare one at home for his wife. Yet a survey just made by this

THIS ARTICLE is the first of several on the automobile problems and habits of medical men. Later articles will report on insurance, upkeep, depreciation, parking, and an assortment of other factors.



magazine among a national cross-section of private M.D.s shows that only one doctor in eight owns *any* kind of Cadillac (solid gold or otherwise); and only one medical man in a hundred owns two.

It's true, though, that a majority of physicians *do* have a second car of some kind. About 56 per cent of those queried own two autos; 4 per cent own three or more.

To put it another way: The median is two cars per doctor (in all sections of the country, among specialists and G.P.s, and among urban and rural doctors). The median is also two cars per doctor aged 60 or under—but it's only one for doctors over that age.

For some further survey findings, take a look at the accompanying tables. In all cases, please note, figures apply *only* to cars used professionally, not to those driven primarily for pleasure. [MORE→



What Make Car?

(Showing makes of cars and percentage
of physicians who drive each)

Ford	14%
Buick	12
Oldsmobile	12
Chevrolet	11
Chrysler	10
Cadillac	8
Pontiac	7
Dodge	6
Plymouth	5
Mercury	4
All others	11



Since Cadillac ranks sixth—quite a bit below the modestly priced Ford, which leads the field—you may wonder why this make has become so widely known as "the doctor's car." Probable answer: Cadillac ownership is six times more common among physicians than among the general population.

About 8 per cent of the doctors surveyed report driving a Cadillac for professional use;

another 4 per cent drive a smaller car professionally but have a Cadillac as a second car. All told, then, 12 per cent of the profession own Cadillacs—as against 2 per cent of the population at large.

As a matter of fact, doctors tend to own more expensive cars than the public, all along the line. Consider these facts:

¶ Of doctors' professional cars, 33 per cent belong in the low-priced field, 45 per cent in the medium, and 22 per cent in the high.

¶ Of the cars sold to the general public within the past year, 60 per cent were low-priced, 34 per cent medium, and only 6 per cent high.

Although Ford is apparently the most popular single make among physicians, General Motors seems to be far and away their favorite manufacturer. One doctor in two drives a General Motors car in his practice; 22 per cent drive Chrysler-line cars; 19 per cent, Ford-line cars. A sparse 9 per cent string along with one of the "independent" makes. (General Motors, by the way, is the sales leader with the public, too; but the public gives Ford the runner-up position over Chrysler.)

General Motors' popularity with doctors is due largely to the fine showing of Buick and Oldsmobile. Oldsmobile seems to be the most popular car among specialists. Buick is the automobile of choice among doctors in the big 40-to-60 age group. [MORE→]

THE CAR YOU DRIVE

(Cont.)

What Year Car?

(Showing vintages of cars and percentage
of physicians who drive each)

1954	14%
1953	32
1952	16
1951	18
1950	11
1949 and earlier	9

One doctor in three, the survey shows, now makes the rounds in a 1953 model. On the whole, though, medical men seem to keep fairly up-to-date: Three out of five drive 1952 or newer models; only one out of ten drives a car that's more than four years old.

G.P.s, despite their usually lower incomes, tend to drive newer cars than do specialists. (This probably isn't surprising, since the average G.P. does more professional driving than does his specialist colleague.) The exact figures: 55 per cent of the surveyed G.P.s have 1953 or 1954 models; only 38 per cent of the specialists do.

Specialists often own more expensive cars, however—which may help account for the slower turnover. The percentage of Cadillac owners, for instance, is more than twice as high among specialists as among G.P.s.



What Model Car?

(Showing styles of cars and percentage
of physicians who drive each)

Sedans	64%
Hard-top convertible	18
Coupe	10
True convertible	5
Station wagon	4
All others	2

Sedans are the odds-on choice with physicians in all main types of practice, age groups, and regions. It's interesting to note that hard-top convertibles, though a relatively new style, are second in popularity. [MORE→]

THE CAR YOU DRIVE

(Cont.)

What Color Car?

(Showing colors of cars and percentage
of physicians who drive each)

Green	29%
Blue	18
Black	14
Two-tone	14
Gray	12
All others	13

Are you still driving around in a staid, black number? If so, you're in the minority; for the survey reveals a definite trend toward the livelier hues.

No one color stands out, statistically speaking; but green manages to hold a "plurality" over its closest rival, blue. Two-tone cars are in the same demand as blacks. Some physicians describe the colors of their cars as (for example): "Hawaiian bronze," "chartreuse and coral," "sun-gold and ivory-cream."

Your Next Car

(Showing makes of cars and percentage
of physicians who plan to buy
each "next time")

Oldsmobile	15%
Ford	14
Buick	12
Chrysler	10
Chevrolet	10
Cadillac	10
Pontiac	6
Plymouth	5
Mercury	5
Dodge	3
All others	10

Are doctors reasonably satisfied with the makes of cars they now drive? Apparently so, for most intend to stick with the same make when it's time to buy a new car.

Yet there's a noticeable tendency to step up to a higher-priced make in the same line: from Ford to Mercury, for example. Practically no physician seems eager to switch to a cheaper car. [MORE→]

It's perhaps significant that, while Ford is the most popular make now driven, Oldsmobile takes first place as the car doctors look forward to owning.

One thing that could (but probably won't) upset future trends is a growing interest in sports cars. Only one physician in a hundred now owns one. But 8 per cent of the men surveyed "would consider" buying one.

Here and there, a doctor already drives a sports car professionally. The Pennsylvania owner of both a British MG and a German Porsche states his case this way:

"A sports car is ideal for a doctor. It's easier to handle, more economical to run. And it can always be parked in front of one's destination —on the sidewalk, if necessary."

But that's not all, he adds. There's also the grand feeling that goes with owning a sports car: "I get a thrill every time I step into my MG. Five of us doctors in this area have sports cars, and the rest would like to but lack the courage to switch over. In another few years, they'll all be driving them."

But sports-car navigating isn't all adventure. A California anesthesiologist says he's had too much trouble getting repairs and service for his Jaguar. So he plans to sell it and go back to "any American car."

Although there may be some disagreement over the best kind of car to own, there's almost universal agreement on one point: that it's always best to buy a brand-new car. Only 8 per cent of the men surveyed bought their present cars used; and a fair share of these doctors say they'll never do it again. END

Are Labor's Health Centers A Threat to Doctors?

More and more unions are dispensing 'complete' care; and some M.D.s are frankly worried by what they consider the handwriting on the wall

By Wallace Croatman

● One day more than forty years ago, officials of the International Ladies' Garment Workers' Union sat down for a serious talk with a New York physician, Dr. George Price. The union was searching for a way to provide low-cost medical care for its members; and it had called on Dr. Price for advice and assistance.

This discussion was to have far-reaching consequences: Out of it was born the first union health center.

When the I.L.G.W.U.'s Union Health Center opened in 1913, it occupied two small rooms in the heart of New York's garment district. George Price, who gave several hours a day to the program, was the only physician on the payroll.

But times have changed. Today, the center is a \$1,750,000-a-year establishment, where more than 200,000 garment workers and their families can get a wide range of diagnostic and therapeutic services. Another Dr. Price—the first medical director's son, Leo—heads a staff of some 170 part-time physicians, who are paid a total of almost \$600,000 a year for their efforts. The union also runs branch clinics in fourteen other cities.

More significant: The I.L.G.W.U. experiment led the

LABOR HEALTH CENTERS



INFORM

XUM

way for similar ones by other labor organizations. There are now at least thirty union health centers scattered from coast to coast; and a number of others are expected to open soon. All told, more than a million workers (plus, in many cases, their dependents) are now eligible for labor-sponsored medical services.

The union health center, then, has become a reality that private physicians can no longer ignore. So let's take a closer look at this growing movement, and let's see how it's likely to affect *you*.

One striking fact about the labor

health center is that it represents a formal alliance between two arch foes of organized medicine: the union leader and the closed-panel devotee. Both of them apparently see the centers as a coldly practical way of getting around "the high cost of medical care."

Moreover, most of the centers have solid financial backing. They are almost always paid for by employers (through that budding phenomenon, the union health and welfare fund). And, since about two-thirds of the nation's 16 million organized workers are covered by health-and-welfare contracts, it's

OLDEST LABOR HEALTH CENTER—run by I.L.G.W.U. in New York—occupies six floors of union-owned building, is open to 200,000 workers and their families.



LABOR HEALTH CENTERS



REGISTRATION ROOM at I.L.G.W.U. center is usually crowded with union members. More than 50,000 people a year use facilities.

not hard to imagine how far the health-center idea could spread—if labor should entirely reject the idea of free-choice health insurance.

In spite of this long-range threat to private practice, however, medical men have so far voiced little opposition to existing union health centers. Why?

In the first place, many of the centers still provide only diagnostic services. Where this is the case, a clinic may actually work closely with private physicians.

The Sidney Hillman Health Center in New York, for example, gets more than 200 requests a month from private practitioners for X-

rays, lab tests, etc. on members or eligible dependents. These requests are filled without charge, and reports are sent to the private M.D. He retains responsibility for treatment—and control of the case.

Such arrangements, it's said, often give the worker diagnostic services that he couldn't otherwise afford. "The fact is," says Dr. Leo Price of the I.L.G.W.U., "many of the people now covered by union-run plans border on the medically indigent class." So they're able to

*According to the New York State Department of Labor, the average worker in the New York City women's and children's garment industry earns less than \$60 a week during peak seasons. During slack seasons, many workers are out of work altogether.

get treatment from private physicians only *because* of free diagnosis.

"Then, too," he adds, "a number of the less-well-paid workers simply don't have a family doctor—and wouldn't in any case. If it weren't for the unions, they'd probably either do without necessary medical care or wind up as charity patients."

Give Income to Doctors

Some medical men tolerate the union health centers for a more personal reason: They work for them.

To doctors in highly competitive city neighborhoods, the union plans may make attractive offers for part-time employment. Usually the physician can arrange his hours to suit his convenience; he's assured of a basic income for the time he puts in at the center; and his work there entails no overhead and no collection problems.

For a variety of humanitarian and personal reasons, then, many medical men haven't wanted to oppose the movement. In fact, some county



SPECIALTY CLINICS account for three-fifths of the physicians' services provided under the I.L.G.W.U. program. (Above: allergy waiting room.) Cost of the center—\$1,750,000 a year—is borne almost entirely by employers.

LABOR HEALTH CENTERS

and state societies have endorsed the health-center principle.

Even the A.M.A.'s Committee on Medical Care for Industrial Workers has spoken favorably of union-run plans. The committee examined twelve centers recently, and found them "well equipped and housed."

It concluded that "an earnest attempt is being made to provide the modern and complete facilities necessary for good clinical service."

But medicine's attitude toward the union centers may soon change. The reason: Labor's programs are rapidly widening their objectives.



STAFF PHYSICIAN (one of 170 employed by the union on part-time, salaried basis) sees patient in one of the I.L.G.W.U. center's fifty-five examining rooms.

Where, formerly, a center was content simply to diagnose ailments and refer patients to private practitioners for treatment, today it's likely to handle the treatment itself. In addition, more and more of the plans are extending coverage to workers' dependents; and more of them are taking in some of the better-paid trades.

A Glance at Tomorrow?

What might the union health center of tomorrow be like? You can get a pretty fair idea by examining one of the most comprehensive plans to come along so far: the Labor Health Institute of St. Louis.

This center (sponsored by the Teamsters' Union, Local 688, A.F.L.) was started in 1945. It covers both union members and their families. All told, some 15,000 people are eligible for a broad assortment of benefits, including the following:

- ¶ Diagnostic services and treatment by staff physicians;
- ¶ Laboratory tests, X-rays, and special diagnostic procedures;
- ¶ Protective measures (e.g., immunizations, periodic physical examinations);
- ¶ General hospitalization benefits;
- ¶ Prescribed drugs and eyeglasses at cost;
- ¶ Dental care (including mouth examinations, X-rays, extractions, and fillings).

Most of these services are dis-



MEDICAL CHIEF of the I.L.G.W.U. project is Dr. Leo Price, son of the surgeon who helped start the center more than forty years ago.

pensed at the center, which occupies three floors of a St. Louis office building. But members can also get medical and surgical care from panel physicians in local hospitals, as well as emergency treatment at home.

Specialists All

Key men in the program are the fifty-odd physicians who work for the institute on a part-time, salaried basis. They're all specialists, with fourteen specialties represented. (Internists and pediatricians fill the roles played by G.P.s in the typical closed-panel set-up.)

As a rule, the staff physicians seem to be quite satisfied with their

LABOR HEALTH CENTERS

lot. There's been only about a 20 per cent turnover of doctors in the past two years—an exceptionally low figure, compared with the experience of other closed panels. Staff doctors claim that they're "reasonably" free from lay pressure. And they're paid well; the hourly wage scales generally approximate what a man could expect to make in his own private practice.

One internist, for example, serves twelve hours a week at the center, spends another five to ten making house and hospital calls—and takes in about \$6,700 a year. A surgeon, who does some eighty operations a year for the center, nets \$7,200.

What about the quality of med-

ical care? A prominent St. Louis surgeon, Dr. Evarts A. Graham, went through the center's clinical records recently—and says the experience "opened my eyes to the advantages of prepaid medical care by a group of physicians . . . When one considers that the average weekly salary [of union members] is only about fifty dollars, it seems almost a miracle that they can obtain such excellent medical service."

Not a Competitor

For two reasons, most St. Louis doctors don't seem to resent the institute. In the first place (as Dr. Graham points out), the majority of the patients treated at the center have low incomes. Many of them might find it hard to afford private care in any case.

Then, too, the health center covers a relative handful (15,000) of the St. Louis population (850,000)—and its members are scattered throughout the city. "We couldn't possibly supplant the neighborhood and family doctors," says one staff physician.

But What If . . . ?

Chances are, you'd have a hard time convincing the average St. Louis doctor that a set-up like this one threatens his financial well-being. But it's interesting to wonder what might happen if a union health center should suddenly take hold in a smaller city—in, say, a place like Akron, Ohio, where more than half



"Thank Heaven! The hospital isn't going to pester us with any more bills. This one says Final Notice."

the population are linked directly with the rubber industry.

Or suppose *all* the unions in a heavily industrialized city decided to open health centers?

Either of these prospects might be enough to make you wince—if

you happened to be a fee-for-service doctor in an area where labor's time bomb was about to go off.

San Francisco doctors have already had to weigh this possibility. Two years ago, the San Francisco Labor Council announced that it

Shell Game

● *The following approximation of a report turned in by a bill collector for the Atlantic Medical-Dental Bureau, Trenton, N. J., bears new witness to the old saw that "Maternity is a matter of fact; paternity, a matter of opinion":*

"Re: Mamie Cannon, who skipped town owing Benton Hospital \$250.

"Found that Miss Cannon had moved three times, finally locating at 42 Elm St., under name of Mrs. Ben Axelrod. Miss Cannon said that she wasn't working, so couldn't pay hospital; and that, anyway, Frank Blivens was the father of her child.

"Interviewed Mr. Blivens, who said that Miss Cannon stayed with Herman Cody, too; that he (Mr. B) *wasn't* the father; and that he had no intention of paying the bill.

"Learned, meanwhile, that Mr. Axelrod is supporting Miss Cannon and child. Told him that if he was claiming them as dependents, he could be held legally responsible for the hospital bill.

"Called on Mr. Blivens again, then on Mr. Cody. Told them that paternity test could be required of both and that whoever was shown to be father could be sued for the \$250 outstanding. Both Blivens and Cody are married. Their wives didn't know what was up. So the husbands didn't want the publicity of a court action.

"Final outcome: Messrs. Axelrod, Blivens, and Cody resolved problem by shaking hands on an agreement to pay one-third of the bill apiece."

planned to set up a city-wide network of health centers. The idea was for 114 local unions to band together in a cooperative venture, aimed at providing complete medical care to organized workers and their families. In a city where more than half the population is made up of union members and their dependents, the mere announcement of this scheme was enough to make many private physicians sit up and take notice.

After two years, the plan has yet to pass the drawing-board stage; but San Francisco medical men are still worried about labor's insistence on "comprehensive" coverage. A few months ago, they got an inkling that the unions haven't changed their tune: Some 12,500 A.F.L. hotel and restaurant workers decided to switch from private insurance carriers to the Kaiser Foundation Health Plan.

As one physician says: "Maybe Kaiser's not union-controlled; but it's the next thing to it."

V.H.I.: A Stopgap?

Is there a warning for medicine in this apparently isolated instance? Some medical men seem to think so. It's true, they point out, that most health and welfare funds still rely on Blue-Shield-type insurance; but there are mounting signs that labor regards such coverage as only a stopgap on the way to more "complete" plans.

Consider, for example, the follow-

ing statement by Dr. Price of the I.L.G.W.U.:

"The insurance industry has thrived most effectively during this period of interest in hospital, surgical, and sickness insurance. The profits in relation to the cost in this business have been remarkable."

Health plan "profits," he adds, are an increasing invitation to the unions. Labor leaders are "beginning to realize that the incomplete—and often very costly—medical service obtained is not adequate for the members covered by insurance policies. Insurance . . . can never replace the value of good medical care, *freely available to the worker.*" [Italics ours.]

Rough Waters Ahead

The odds are strong that labor will step up its demand for more union health centers in the years ahead. Still, there's one consolation (of a sort) in labor's attitude: As the unions' vested interest in closed-panel plans grows, their interest in compulsory health insurance bids fair to diminish.

Says one union executive: "Do you think that, after all the hard work we've put into building our medical organization, we're going to let a crew of Government bureaucrats come in and tell us how to give medical care to our members? Not on your life!"

Maybe private medicine and private labor have something in common after all.

END

A Well-Planned Office For a Family Doctor

Imaginative treatment of layout and furnishings helps make this an efficient—though in some ways unconventional—set-up for solo practice

By Lois Hoffman



NO FRILLS on this unadorned modern building. But antique brick, used on some exterior and interior walls, adds variety and color. Since there are no steps to climb, cardiacs and other disabled patients enter the office without difficulty. From a side street the doctor drives into the car port, at left. [MORE→]

A WELL-PLANNED OFFICE

- "If you're building a new office, choose a good architect, tell him what you need, then let him alone."

That's the advice of Madison Reeves Pope, a Plant City, Fla., general practitioner. His architect, Mark Hampton of Tampa, took plenty of time to study other medical offices, then designed not only the building but also many of the furnishings.

"Naturally, I was asked to approve floor plans and other arrangements," says Dr. Pope. "But I don't remember suggesting a single change." Result of this hands-off policy: The doctor now has a first-rate office.

Since the building has four fully equipped treatment



rooms, including one for minor surgery, he can handle his large practice efficiently and easily. Treatment rooms and lavatories are all only a few steps from the reception area; yet they aren't in full view of waiting patients. And provision has been made for future expansion.

The architect seems to have kept in mind the triple advantages of beauty, economy, and privacy. To cut down on illumination costs, for instance, he put a wall-length window in all outside rooms except the utility and storage room. But the glass is either well curtained or not transparent. And outdoor bamboo screens at each end of the building help shut off the view from side streets.



FOCAL POINT of the floor plan is the secretary's station, which allows excellent control of office traffic. The separate reception room for Negro patients could, in another part of the country, be used perhaps for children. Four rooms at far right (including new location for laboratory) are to be added later, as the practice expands.

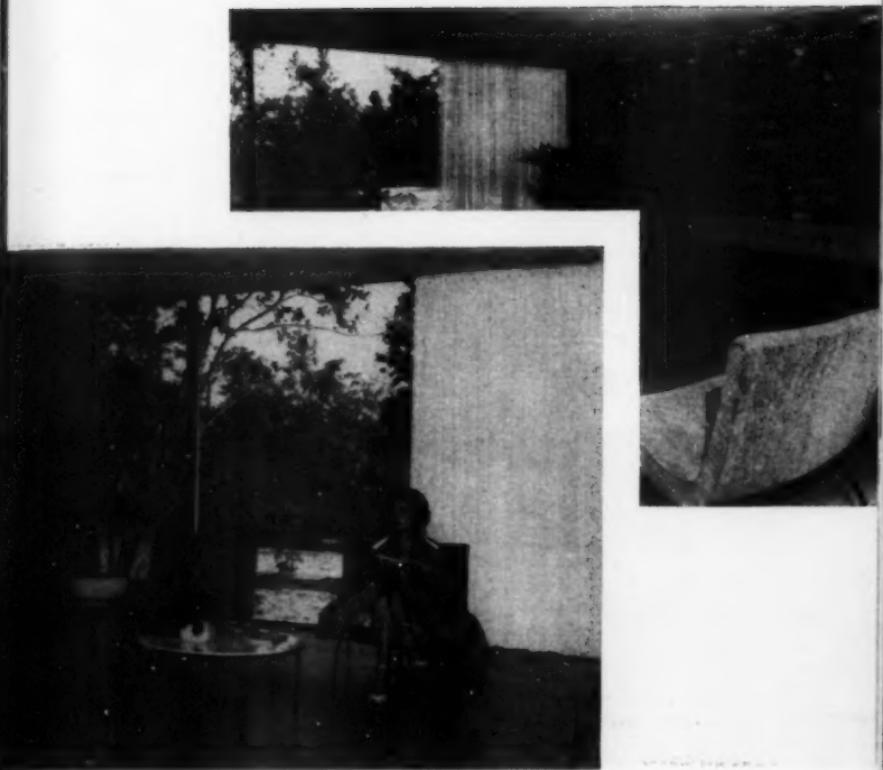
[MORE→]

A WELL-PLANNED OFFICE



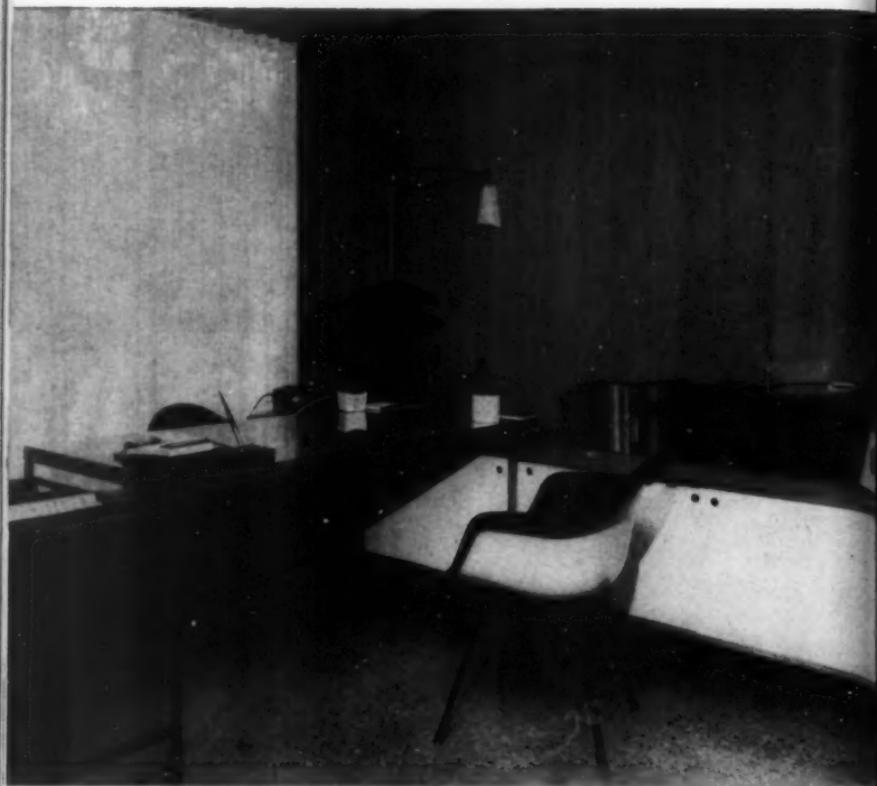
EYESORE INTO ASSET: Conventional green filing cabinets were spray-painted black and white to match other furnishings and add decorative note. Unlike many offices, this one has plenty of space for additional files.





WROUGHT-IRON FURNITURE, in evidence throughout the building, is durable and inexpensive. The attractive sofa is generously oversized but not overused, because most waiting patients prefer to sit alone. While the picture window (partly shielded by draperies and an outside screen) gives ample light during the day, more indoor lighting fixtures would seem desirable to make reading easier for waiting patients. [MORE→]

A WELL-PLANNED OFFICE



UNUSUAL DESK has a plain birchwood top covered with glass. Attached to one side is a suspension-type file with folders hanging from hooks that fit over runners. Sliding doors on the cabinets save space, have no hinges or other breakable parts. Floors throughout the building are terrazzo (small marble chips set in cement and highly polished).

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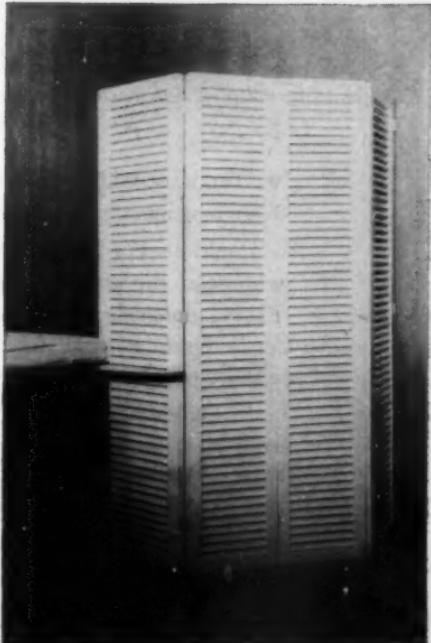
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WALL-LENGTH WINDOW in the treatment room gives plenty of light, with no loss of privacy, since the lower panel is translucent glass. The louvers at the side can be opened for ventilation if the air-conditioning unit is out of service. A thick slab of marble on top of each cabinet provides a durable working surface. Cabinet fronts are wood, heavily lacquered to resist stains. Designed by the architect, the wrought-iron table cost \$62.

LOUVERED SCREEN is attached to wall at right. Extended, as here, it forms a convenient dressing cubicle; and when not in use, it can be folded back against the wall.

END





The Man Who Creates Rex Morgan

A young doctor dreamed up this 'purposely un-comical comic strip.' Today it's a hit with funnies fans—and with real-life physicians too

By Mauri Edwards

- "The most widely known physician in the U.S.," says Time magazine, is handsome Rex Morgan, M.D.

Could be. For Rex practices in full view of the millions who read the comic pages of their daily newspapers. There, alongside Dick Tracy and Joe Palooka, he tirelessly fights disease, fearlessly exposes quackery, and quietly preaches the gospel of good medicine.

In his six-year career in newsprint, Rex Morgan has won such complete acceptance from real-life medical men, as well as from the comics-conscious public, that his creator recently stepped from behind the nom de plume Dal Curtis and revealed himself as Nicholas P. Dallis, 42-year-old Toledo, Ohio, psychiatrist.

Whereupon the A.M.A. pinned a verbal medal on him

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XUM



PSYCHIATRIST NICK DALLIS is the man behind Morgan. His medical comic strip appears daily in about 300 newspapers and is followed by an audience in the millions.

ALWAYS ETHICAL AND COURAGEOUS, Dr. Morgan consistently dispenses good medicine, occasionally mounts a soap box to educate the public, and tirelessly fights against dope peddlers, faddists, and charlatans.

EX MORGAN, M.D.

By DAL CURTIS



REX MORGAN, M.D.

at its 1954 San Francisco convention. Said the trustees: Dr. Dallis' Rex Morgan "has come to typify the modern doctor—a man of high principles, intelligence and integrity, devoted to the service of his patients, and yet a truly human, compassionate individual."

This isn't the first time the A.M.A. has taken official note of Rex Morgan and of the effective publicity job he does for U.S. medical men. A year ago, the then A.M.A. President, Dr. Edward J. McCormick (also of Toledo), praised Morgan's "significant contributions to the American people." He added that "I have yet to receive a criticism from a physician concerning the contents and approach used" in the comic strip.

Besides being the recipient of such testimonials, Rex Morgan has twice been written up in Time. And cartoonist Al Capp has paid him perhaps the ultimate compliment—by lampooning him in his Li'l Abner strip as Rex Mudhen, M.D.

This widespread recognition rather bewilders amiable, easy-going Nick Dallis. After all, he points out, he created his "purposely uncomical comic strip" largely as a hobby. "Some people build ship models; I build Rex Morgan," he says.

Dr. Dallis always wanted to write a comic strip; but, even more, he wanted to study medicine. He worked his way through Washington and Jefferson College by wait-

ing on tables—and found enough spare time to win a collegiate boxing crown as a middleweight (he's a heavyweight now). In Philadelphia, he got his M.D. (at Temple University) and met the nurse who became Mrs. Dallis after his internship.

They settled down near Reading Pa., "and I was going to be a general practitioner," says Dallis. "Every time the doorbell rang, I'd put on my white coat, and my wife would put on her nurse's cap. But it would only be another salesman."

Finally, a year or so later, G.P. Dallis decided to try obstetrics. But after three months as a resident, he switched to psychiatry; and this time he completed a full four-year residency (in Detroit).

Finally, he settled down in Toledo, where he took over as director of the Mental Hygiene Center and as psychiatric consultant to the juvenile court. Meanwhile, he also developed his own private practice in partnership with two other psychiatrists; and he eventually cut loose from his city posts.

Morgan's Debut

It was during his early days in Toledo that Nick Dallis succumbed for good and all to the bite of the comic-strip bug. He tried out several ideas before settling down with Rex Morgan, M.D. And he maintains today that he never *would* have hit on his highly successful formula without the friendly advice of Tol-

doan Allen Saunders, who writes the Mary Worth and Kerry Drake strips.

Saunders directed Dallis to a Chicago syndicate which jumped at the chance to handle the Morgan strip. Since Dallis is only an amateur cartoonist himself, the syndicate turned the drawing of Morgan over to two professionals—Marvin Bradley and Frank Edgington.

Then, on a May day in 1948, Rex Morgan at last launched his comic-page practice. That very day, appropriately, Nick Dallis took and passed his psychiatric board exam.

Since then, Drs. Dallis and Morgan have had some hectic times together in print. They've fought a dope ring, a quack hypnotist, a herb doctor. They've delivered sugar-coated lectures on mental health, cancer, polio. They've patched up patients and marriages.

No Time for Love

Marching with Morgan through his countless medical experiences is his loyal nurse, June Gale. Besides bringing glamour to the strip, June is often a handy prop to be rescued from disaster. When Rex is clubbed by dope thieves, for example, June, bound and gagged, is wrested from her captors just before death strikes. Another time, when June falls into the clutches of a manic depressive, Rex gets to her side in the nick of time.

But worst of all for June: Her very obvious charms seem to make

no impression on her bachelor boss. This distresses her no end. It also distresses Mrs. Nick Dallis, who—as an R.N. herself—feels that a pretty nurse deserves better of life. "He'd marry her if he had any sense," says Sally Dallis.

She keeps up with Morgan by reading the proofs—a month's worth at a time. The three Dallis youngsters rarely see the strip, though. At Dallis' insistence, Rex doesn't practice in Toledo newspapers. "I wouldn't want my patients to think I'm putting them into my stories," he says.

Toledo is one of the few Morganless cities left. About 300 U.S. newspapers now carry the strip. Its popularity has spread abroad, too. It appears in Mexico, in Cuba, and



"Boil some ice!"

even in Stockholm—where, for reasons that escape its originator, the Svenska Dagbladet calls the doctor Rex Morton, M.D.

It's Strong Stuff

The rise of Morgan-Morton hasn't been without momentary setbacks. Since Dallis' creation is, after all, comic-strip fare, it by no means avoids the sensational and melodramatic; and some readers and editors have objected to certain sequences. One paper canceled the strip because of a story involving a suicide. Another dropped a chapter dealing with euthanasia.

Even so, Morgan's circulation has continued to grow. The strip is now firmly established as one of the most popular two or three in the nation—especially among women.

And, for the most part, its audience isn't squeamish. Dallis' syndicate got up to 500 letters of praise a day for a recent episode on leprosy. The doctor tackled this delicate subject because of a tactical error he'd made in an earlier Morgan yarn.

Bawling out a nasty character, Rex Morgan accused him of treating a certain woman "like a leper." Patients at Carville, La., objected to the phrase and expressed their objections in writing. So Rex Morgan made amends by doing battle against the prejudices of a small town that had blindly ganged up on a man who'd been cured of Hansen's Disease.

At one point in this episode, Rex declared that leprosy "is not highly contagious! It is not unclean, and it is not dreadful. It is only our ignorance that has made it so."

In appreciation, an official of the leprosy-fighting Leonard Wood Memorial Foundation wrote Nick Dallis: "Your contribution is probably the greatest that has been made, at least in this country, to this all-important problem."

Doctors in general feel that Rex is right in there with them, doing his bit to help stamp out disease and educate the public. When the St. Joseph (Mo.) News-Press decided to put out a special medical section, for instance, local physicians insisted that a Rex Morgan strip be included.

Better Than Medicine

It's perhaps understandable, then, that Nick Dallis regards Rex Morgan as more than just a comic-strip character. "I feel that Rex is a very real person," he says. "I think of him as a G.P.—or perhaps more of an internist. We've never had him in a maternity case, and he does no surgery—although he assists on his own cases.

"Rex probably had a couple of years of hospital training and then went into service. He's highly ethical. One woman wanted him to give her tablets she didn't need. Rex stood by his guns. He lost the patient, much as he needed patients right then."

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Dallis writes Morgan three months ahead of the strip's appearance in print, rattling off a week of continuity at once. So, what with his full-scale psychiatric practice, his schedule is pretty crowded. Twice a week, in fact, he gets up at 5 A.M. and goes to his empty office to write until it's time for him to make hospital rounds.

Morgan has grown so popular that there's now talk of doing a television series, with Dallis supervising rather than writing. That project is still indefinite; but the doctor has plenty, meanwhile, to keep him busy. He does an occasional turn

on the lecture platform, and he has written papers for such publications as *The American Journal of Psychiatry* and *The Ohio State Medical Journal*.

These days, he also presides over a second comic strip: *Judge Parker*. The Judge, a kind of Morgan of the courtroom, is doing so well that he recently won Dallis a Freedom Foundation award. Even so, this energetic writer-psychiatrist confesses that he's worried about Parker's future. The reason: "I keep wondering what lawyers will say when they realize that a doctor is writing about them." END



How Your Savings Grow

If you're laying a nest egg for retirement, these tables will help you gauge its size

By Jon Russell

● Want to make your savings program more systematic? Then the figures that follow can help you. They'll tell you (for various periods and at various interest rates):

1. What any lump sum you now have will grow to;
2. How much you must save each year to accumulate a given sum;
3. What your present savings will amount to later on.

Take a specific example: Assume that you're 42½ years old and would like to quit practice at 60, with a retirement fund of \$135,000. Assume also that you've stashed away \$25,000 so far. And, finally, say that you've lined up investments that should pay you, on the average, 3½ per cent annually.

Here's how to figure what you must save and invest each year from now on:

First, you want to find out what your \$25,000 reserve fund, tucked away at 3½ per cent, will amount to in 17½ years, when you turn 60. For this, you use Table 1.

Table 1 shows you that \$10,000 invested at 3½ per cent will grow to \$16,828 in fifteen years, to \$20,016 in twenty years. By splitting the difference between these two figures, you get the 17½-year total. It comes out to \$18,422.*

[MORE TEXT ON 136→

*Such interpolations are slightly off (because the table reflects a geometric, rather than an arithmetic, progression), but are accurate enough for practical purposes.

TABLE I

What a Lump Sum of \$10,000 Will Grow To

<i>Rate of Interest*</i>	<i>In 10 Years</i>	<i>In 15 Years</i>	<i>In 20 Years</i>	<i>In 25 Years</i>	<i>In 30 Years</i>	<i>In 35 Years</i>
2%	\$12,202	\$13,478	\$14,889	\$16,446	\$18,167	\$20,068
2½	12,820	14,516	16,436	18,610	21,072	23,859
3	13,469	15,631	18,140	21,052	24,432	28,355
3½	14,148	16,828	20,016	23,808	28,318	33,683
4	14,859	18,114	22,080	26,916	32,810	39,996
4½	15,605	19,494	24,352	30,420	38,001	47,471
5	16,386	20,976	26,851	34,371	43,998	56,321
5½	17,204	22,566	29,599	38,823	50,923	66,793
6	18,061	24,273	32,620	43,839	58,916	79,178
7	19,898	28,068	39,593	55,849	78,781	111,128
8	21,911	32,434	48,010	71,067	105,196	155,716

Table computed by Financial Publishing Co., Boston. Copyrighted, 1924, by Medical Economics, Inc. *Compounded semi-annually.

[MORE→

TABLE 2
How Much You Must Save Each Year to Accumulate \$100,000

<i>Rate of Interest*</i>	<i>In 10 Years</i>	<i>In 15 Years</i>	<i>In 20 Years</i>	<i>In 25 Years</i>	<i>In 30 Years</i>	<i>In 35 Years</i>
2%	\$8,949	\$5,665	\$4,031	\$3,057	\$2,413	\$1,957
2½	8,701	5,434	3,812	2,850	2,216	1,771
3	8,458	5,210	3,604	2,654	2,033	1,598
3½	8,222	4,994	3,405	2,470	1,862	1,440
4	7,991	4,786	3,214	2,296	1,702	1,295
4½	7,765	4,585	3,033	2,131	1,554	1,162
5	7,545	4,390	2,860	1,977	1,417	1,040
5½	7,331	4,203	2,695	1,832	1,291	930
6	7,121	4,022	2,538	1,696	1,174	830
7	6,718	3,680	2,247	1,450	967	657
8	6,334	3,363	1,985	1,235	793	518

Table computed by Financial Publishing Co., Boston. Copyrighted, 1954, by Medical Economics, Inc. *Compounded semi-annually.

TABLE 3

What \$1,000 Saved and Invested Each Year Will Grow To

<i>Rate of Interest*</i>	<i>In 10 Years</i>	<i>In 15 Years</i>	<i>In 20 Years</i>	<i>In 25 Years</i>	<i>In 30 Years</i>	<i>In 35 Years</i>
2%	\$11,175	\$17,654	\$24,810	\$32,716	\$41,448	\$51,094
2½	11,493	18,404	26,228	35,083	45,119	56,478
3	11,823	19,193	27,746	37,672	49,192	62,562
3½	12,163	20,022	29,370	40,490	53,715	69,447
4	12,514	20,895	31,110	43,563	58,742	77,246
4½	12,878	21,812	32,973	46,916	64,333	86,091
5	13,253	22,778	34,970	50,578	70,556	96,130
5½	13,641	23,794	37,110	54,577	77,488	107,538
6	14,043	24,863	39,406	58,949	85,213	120,511
7	14,886	27,174	44,507	68,957	103,447	152,097
8	15,827	29,736	50,382	80,943	126,182	193,145

Table computed by Financial Publishing Co., Boston. Copyrighted, 1954, by Medical Economics, Inc. *Compounded semi-annually.

[MORE→]

Now, your \$25,000 reserve fund is $2\frac{1}{2}$ times the \$10,000 lump sum used as an example in the chart. So you simply multiply the \$18,422 result you just got by $2\frac{1}{2}$. The answer: \$46,055. This is what your *present* savings will grow to, assuming immediate reinvestment of all income from your fund (and also assuming that the income is paid, or the interest compounded, semi-annually).

But the *total* sum you want to accumulate is \$135,000. So, knowing that your present nest egg will give you \$46,055, you next need to figure how much money you're going to have to save annually to amass \$88,945 besides.

This you can do by using Table 2 in much the same way as you used Table 1. First, you find out what you'll have to save and invest each year for $17\frac{1}{2}$ years at $3\frac{1}{2}$ per cent to wind up with \$100,000 (the sum used as an example in this chart). The answer turns out to be \$4,200.

But since you're aiming to save not \$100,000 but \$88,945, you multiply the \$4,200 result you just got by .88945. This gives you the amount you must plan to set aside each year: \$3,736.

Good Homework

Not a bad stunt, of course, is simply to give these tables and the figures you have in mind to your grammar-school son as part of his homework. Then have his older sister check him. If they're handy at it, you can even turn them loose on Table 3, to find out where your current annual savings rate will get you. Nice object lesson for the kiddies, too. Computing from Table 3 is the same as from the others.

By the way, it's assumed in Tables 2 and 3 that your savings are available for investment at the *beginning* of each year. If they're not available until the end of each year, subtract one year from the period you're allowing yourself to amass the sum you want. Either that, or figure on retiring a year later. In the problem just cited, for example, you'd use a $16\frac{1}{2}$ year period—or count on retiring at 61. END



"That's the last time I'll ever casually drop into a doctor's office for a check-up."



I Shoot Patients

The author's weapon is a camera, of course. And pictures like hers have proved so useful to doctors that many of them now make their own

By Nancy G. Reidenbach

● A radiologist paid me a welcome compliment the other day. I had just taken pictures of a man who'd come to him for treatment of a neglected basal cell carcinoma of the face. Much of the man's nose had been eaten away. When I walked out of the therapy room with my camera, the doctor followed me into the corridor.

"You know," he said, "you're extremely important to me in a case like this. I wouldn't have dreamed of start-

I SHOOT PATIENTS

ing treatment on that man without knowing that your pictures would be available for the record. Just suppose he were to say I burned off his nose with my X-rays. I'd have your pictures to prove how he looked before I started."

When I first set up the photography department at Herrick Memorial Hospital in 1951, many of the physicians there were frankly skeptical. Today, they keep me so busy that my husband says ours is

the only known case in which a doctor accuses his wife of neglect.

Our radiologists—like the one quoted—have good reason for wanting photographs of therapy patients with visible lesions. They've learned that a picture of the original condition is first-rate malpractice insurance. Many plastic surgeons, too, say they feel safer when I make a "before" shot for their records.

Nor are malpractice actions the only legal scuffles in which medical



PHOTO FANCIERS John and Nancy Reidenbach relax at home after a hard day of medicine (for John) and picture taking (for Nancy). Mrs. Reidenbach credits her doctor-husband with inspiring her success in medical photography.

The Woman

► When Dr. John C. Reidenbach rushes to make 8 A.M. surgery at Herrick Memorial Hospital in Berkeley, Calif., his 32-year-old wife, Nancy, often rushes with him. She has, by then, not only prepared herself for the day but bathed and dressed four children, supervised breakfast for the family, packed three of the youngsters off to school, and given the maid instructions for the care of the fourth, a baby.

She's not an M.D., though. She's a medical photographer.

Nancy Reidenbach describes herself as "an avid snapshooter since girlhood." But she became a professional photographer only about six years ago. She started out doing children's portraits to support her

photographs may be of importance. I recall a case of a small boy who had been attacked by a dog. The child was rushed to the hospital, where I was asked to photograph the extensive lacerations of the youngster's scalp. Months later, the pictures helped the boy's parents win a substantial claim from the dog's owner—without going to court.

Sometimes my pictures *do* turn up in a courtroom. Not long ago, for instance, a physician I'd done some

work for was called on to testify in an accident case. He was asked to describe the victim's condition at the time of his initial treatment.

"I'll do better," said the doctor. "Take a look at these pictures."

In other court cases, I've seen medical photographs prevent a defendant from minimizing his victim's injuries. I've also seen them discourage the victim from exaggerating his injuries.

Outside as well as inside the

Behind the Camera

hobby. A couple of years later, when her husband beckoned for help, she turned to medical photography.

John Reidenbach is an industrial surgeon. He wanted photographic records of some of his cases. But though he's handy with a camera himself, he found that many of his most important shots had to be taken in surgery when he was scrubbed and couldn't do the job himself. "So I was drafted," says his wife.

But she's never regretted it: "I'd sooner photograph even a long, bloody operation than tackle some of the little demons I used to urge to 'Watch the birdie,'" she says.

Mrs. Reidenbach's work so impressed Herrick's doctors that administrator Alfred E. Maffly encour-

aged her to set up a photography department at the hospital. She runs it on a fee-for-service basis and is starting to show "a modest profit."

In the accompanying article, Mrs. Reidenbach relates some of her experiences in medical photography and drops a few hints to prospective doctor-photographers.

"After writing it," she confesses. "I had a horrible dream. I saw men in white staggering about under bristling loads of photographic equipment. They were so busy taking pictures that they had no time to treat their patients. Wide awake, though, I sincerely hope that more and more physicians will realize how useful a tool photography can be in medical practice."

I SHOOT PATIENTS

courtroom, doctors can use medical photographs in almost limitless ways. Here are some examples from my experience:

¶ Photographs can help convince a patient of the need for treatment.

I know an orthopedist who collects pictures of almost all his cases. By means of these, he can often illustrate for a patient the kind of treatment he'll get and the results he can expect. "Nothing reduces fear and builds confidence so fast," he tells me.

¶ Photographs can keep the patient posted on his progress.

An internist I work with gets me

to photograph most patients he treats for obesity. I remember one woman who weighed almost 200 pounds when I first shot her. Next time, she had lost nearly ten pounds. The third time, she was down to 185.

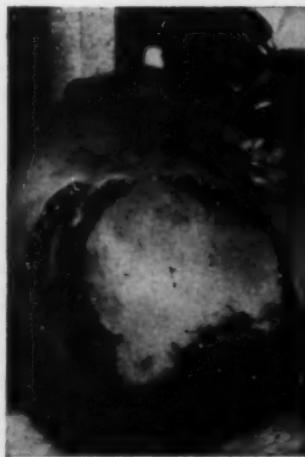
About five pounds later, though, her will power began to sag; so the doctor whipped out the progress pictures. One look at what she had been, and the woman's determination stiffened again.

¶ Photographs can help cut paperwork.

A surgeon with a large industrial practice tells me he used to be

How medical photography Pays Off

...and how it can help you too



WON A SETTLEMENT: Pre-treatment picture of a dog-bite injury spared this boy's family the harassment of a court battle.

swamped with insurance forms. Then he began routinely to submit photographs with his reports. "I'm amazed at how well it works," he says. "The claims adjuster gets a crystal-clear idea of the injury and the treatment, so he rarely has to bother me for additional information. What's more he's also unlikely to question my fee."

For the Record

¶ Photographs supplement the doctor's records.

One surgeon at Herrick always makes it a point to call me when he's doing an operation in which no tis-

sue or specimen is to be removed. The reason: He feels that my pictures will back up his report on the conditions he found and the procedure he followed.

¶ Photographs bolster the doctor's memory.

"My visual memory is poor," an internist told me some months ago. "My written words soon become just words to me. So I've come to depend on my 'photographic memory.' Months after I've finished with a patient, I can take a picture from my files, and his case will be vividly before me."

Those are the most obvious uses



ASSURED SURGEON'S FEE: One look at these shots of a burn-graft case convinced the insurer that the bill was justified.



CONVINCED ADJUSTER: With this photo, the doctor let the insurance company judge a compensation claim case for itself.

I SHOOT PATIENTS

of medical pictures; but they're by no means the only ones. Certainly, you can photograph a dermatitis more easily and more accurately than you can describe it. Endocrinologists find photographs priceless in recording body habitus—including height, fat and hair distribution, facies, genital development. Orthopedists use them to record deformity and range of motion.

Some pathologists I know film gross specimens while fresh—before they're cut or fixed. One has a camera so arranged that it can be lowered over his microscope to record a field that particularly interests him.

Some of my doctor-friends even cart cameras to medical conventions, so they can shoot interesting charts and exhibits that they haven't time to study on the spot.

Others make pictures to illustrate their medical articles. And, since this is an era of visual education, still others prepare their own slide lectures.

Says It Isn't Hard

Naturally, some physicians take pictures simply because they enjoy it. But necessity makes photographers of others. For it's a fact that, outside of big university hospitals



AVERTED BLAME FOR SCAR:
But for this photo, an auto-accident victim might have tried to win damages from the doctor.



EXPLAINED A PROCEDURE:
Could 10,000 words tell as much about free-graft technique as do these photos?

and certain government installations, photo departments like the one I run are surprisingly scarce. If you want pictures of *your* work, you may have to take them yourself—or at least teach someone else how to take them.

Actually, learning medical photography is easier than you might suppose. And the doctor who wants to tackle the job himself starts out with several advantages that I lacked at the beginning:

1. He knows medicine; so he knows exactly what he wants to get on film.

2. More than likely, he neither

needs nor wants to photograph as wide a variety of subjects as I take (my department has run the gamut from high-power photomicrographs of dogs' eyes to transilluminated infants). So he needn't learn all the fine points.

3. By the same token, he doesn't have to buy a lot of costly equipment.

It Can Be Costly

I have to admit that when the shutterbug bites, it sometimes bites hard. I remember one physician who found my photographs so useful that he decided to take his own:

His first step was to buy the fanciest imported camera he could find. Before he could use it in his work, he found that he'd have to have another lens, a flash synchronizer, and view-finding and range-finding gadgets. The extras practically doubled his investment.

As it happens, a doctor can get just about everything he needs from a basic outfit comparable to my own (which cost me roughly \$400 to assemble). Here's what it consists of: a 35-mm. single-lens reflex camera, an extension bellows, a 50-mm. lens, a 104-mm. lens, an electronic flash, and a ring light for the flash.

Good for Operations

This equipment is particularly well suited for use in surgery. With it, I can work two to four feet from the patient; so I don't have to intrude on the sterile field. Besides,



PROVED ORIGINAL LESION:
To complete record of tongue-cancer case, a Herrick Doctor had this photograph taken.

I SHOOT PATIENTS

the electronic flash, in the operating room, is safer than flash bulbs (although I always make a point of consulting with the anesthesiologist before using *any* flash equipment. And it works beautifully with color film.

There are, of course, several excellent special cameras on the market for medical work. These are designed for close-up and cavity shots, and they all but do away with the need for technical knowledge.

But, speaking personally, I find I can do everything I want at less cost. What's more, I feel that the camera that reduces technique to a mechanical process also loses a certain amount of flexibility. It's a matter of opinion, of course.

'Just Keep Shooting'

Once you've assembled your equipment, you'll probably do just what I did when I started out: You'll keep shooting till you learn how to get the best results.

My first cases were burns and mangled hands from my husband's industrial practice. The only reason I got usable results at all was that I took enough pictures at enough exposures to be sure I'd get *something*. And I can't recommend a better way of learning, although an assortment of manuals is available to help you if you want to try to shorten the trial-and-error period.

By the way, though I do a fair amount of work in black and white, I concentrate on color. You'll un-

doubtedly do the same. Many medical subjects are difficult, if not impossible, to portray except in color.

As for developing—well, I develop some of my own black and white pictures, but I have my color processing done outside. I've learned I can't compete with automatic machinery.

Photos and the Law

One other lesson I learned right at the start: Unless the medical photographer is careful, he can get snarled in lawsuits. Recently, for instance, I heard about a doctor who was sued for making and displaying unauthorized movies of an operation.

Such embarrassments can, of course, be avoided. The same principles of law that apply to your practice apply generally to your picture-taking. At Herrick, we feel that the consent-to-treatment form signed by a patient on admission covers pictures taken strictly for his medical record. But if there's any chance that the pictures will be published, I see to it that the patient signs a dated, witnessed release, giving us permission to photograph him for his medical record or for use in a scientific or other publication, with the understanding that his name will not be used.

Usually, I let a nurse handle the release, just as she does the surgery permit. (Of course, it's helpful if the doctor has already explained what he wants and why.) Usually,

then, patients are quite cooperative about my work.)

Many are rather proud that their physician is interested enough to want pictures. I've had patients remark that the doctor "must be on the ball to use such advanced techniques." In addition, picture-taking sometimes brightens the drab hospital routine for a patient.

Just a few days before I sat down to write this article, I had an orthopedic case—a boy going on 13 who

had never been able to walk. There he was—in a hospital room, separated from his family, with his birthday just a day or so off.

After making the required pictures, I used up the rest of my film snapping shots that the youngster could send home. I've never seen such a grin as the one that lighted his face when I later gave him a set of the prints. It made me feel as if I'd almost had a hand in treating him.

END



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"Oh, but I couldn't be . . . I'm not married!"

How to Figure Depreciation Under the New Tax Law

Revised provisions for faster write-offs will give some doctors a strong incentive to replace old equipment with new. Here's why

By Wallace Croatman

- If your professional equipment shows signs of age, now may be the ideal time to start replacing it. Reason: The new Revenue Code offers clear-cut tax advantages to physicians who invest in new equipment this year, or any subsequent year.

The chance for tax saving lies in the greater flexibility you're now allowed in figuring depreciation on such equipment. Under the old law, you took depreciation deductions in equal annual amounts, spread over the useful life of the asset. Today, you have a choice of several methods, two of which provide a considerably faster depreciation rate. In some cases, you can write off more than two-thirds of the cost of a capital asset during the first half of its estimated useful life.

This isn't to say that you'll necessarily want to take advantage of the new provisions. They don't allow you to claim any *more* depreciation on an asset; they simply let you write off a larger portion *in the early years*.

A key question, then, is: What will your income prob-

SEVERAL TAX EXPERTS contributed materially to this article. The editors were especially fortunate in having the help of John C. Post of Washington and Joseph McElligott of New York.

ably be a few years from now? If you expect it to be substantially higher, you may want to save a good part of the depreciation allowance on new equipment for the years when you'll be in an upper tax bracket. In that event, you'll probably elect to keep figuring depreciation by the same method you've used right along.

Remember, too, that the new methods can be applied only to assets you purchased *new* since the start of 1954. So probably the bulk of your equipment must still be depreciated by the old "straight-line" method. You can't use the new provisions on items you've bought second-hand—or on items with an estimated useful life of less than three years.

Now let's take a closer look at the various depreciation methods spelled out under the new law. The following three are the ones most applicable to professional equipment:

1. *The "straight-line" method.* This is the method just about every medical man has been using—and must keep on using for assets bought before this year. It's certainly the easiest method: You simply take the cost of an asset, divide by its years of estimated useful life, and deduct the result, as depreciation, each year. Thus, a \$1,000 X-ray machine with an estimated life of ten years gives you an annual deduction of \$100.

2. *The "declining-balance" method.* This amounts to a new alternative (though a less liberal declining-balance formula was allowable under the old law). Its great virtue is that it permits fast write-offs on new assets—especially during the first year. Here's how it works:

First, you find the depreciation percentage you're allowed each year under the straight-line method. That's 10 per cent, in the case of the X-ray machine mentioned above. Now double that percentage—and in the example cited, you get 20 per cent. This is the percentage you de-

DEPRECIATION UNDER THE NEW TAX LAW

duct each year from the *undepreciated balance* of the asset's value.

Thus, in the first year of a \$1,000 X-ray machine's lifetime, you can claim a \$200 allowance. In the second year, you take only \$160 (20 per cent of the \$800 undepreciated balance). The third year, you take \$128 (20 per cent of the remaining \$640). And so on, down through the useful life of the machine.

One Drawback

Because it permits an accelerated write-off, the declining-balance method is expected to spur some doctors into replacing old equip-

ment. (The whole purpose of the new provisions, in fact, is to encourage businessmen and others to invest in new assets—thus giving industry a shot in the arm.) But the declining-balance method has at least one potential drawback:

Under it, you can't write off the complete cost of an asset during its useful life (depreciation always being figured as a percentage of the remaining balance). With that \$1,000 X-ray machine, for instance, you'll have \$107 left in unused depreciation at the end of the tenth year.

But there's a way of getting



"The doctor can't seem to find what it is I'm allergic to.
Do you suppose it could be you, dear?"

around this drawback: You simply switch from the declining-balance to the straight-line method—which you're allowed to do at any time. With the illustration we're using, you'll have deducted slightly more than two-thirds of the X-ray machine's purchase price at the end of five years; you'll then have \$328 still to be written off in the remaining five years. To get credit for the entire amount, just divide \$328 into five equal annual installments—and wind up by deducting \$65.60 a year for five years.

3. *The "sum-of-the-digits" method.* Here the rate of depreciation is expressed as a fraction. The denominator is constant—the "sum of all the digits" in the estimated useful life of the item. For a ten-year asset, you add 1 plus 2 plus 3 and so on down through 10, coming up with a denominator of 55.

The numerator of the fraction gets progressively smaller. For a ten-year object, you start with the figure 10 and work down through 9, 8, 7, 6, and so forth.

How do you apply this fraction? Well, with our \$1,000 X-ray machine, you deduct $10/55$ of the purchase price (or \$182) the first year; $9/55$ (or \$164) the second; $8/55$ (or \$145) the third; etc. Note that the fraction is always figured against the *purchase price* of the item (\$1,000)—never against the remaining balance.

Now, let's compare the three methods as they apply to one of your

most important depreciable assets—the car you drive professionally.

Suppose you bought a new Buick on Jan. 7, 1954. Suppose you paid \$3,200 cash for it, without a trade-in. The car, we'll say, has an estimated useful life of four years; and you plan to use it for professional purposes only. The following tables show how you figure depreciation under each of the three main methods.

First, the familiar straight-line depreciation:

	Annual	Cumulative
First year	\$800	\$ 800
Second year	800	1,600
Third year	800	2,400
Fourth year	800	3,200

Next, declining-balance depreciation:

	Annual	Cumulative
First year	\$1,600	\$1,600
Second year ..	800	2,400
Third year ...	400	2,800
Fourth year ...	200	3,000

And finally, here's sum-of-the-digits depreciation on the same car:

	Annual	Cumulative
First year	\$1,280	\$1,280
Second year ..	960	2,240
Third year ...	640	2,880
Fourth year ...	320	3,200

As these examples show, you get a much faster write-off under either of the new formulas than under the

DEPRECIATION UNDER THE NEW TAX LAW

old straight-line method. By and large, there's not much to choose between the two new methods.

The declining-balance formula, it's true, lets you deduct a greater percentage of a car's cost during the first year. But the sum-of-the-digits formula lets you claim more in each of the following three years. Moreover, the latter method enables you to use up your full depreciation allowance over the four-year stretch—whereas the declining-balance method leaves you with a \$200 unused balance.

At one time or another, you'll probably sell or junk certain items

of used equipment. When that happens, you'll bump into the problem of "salvage value."

According to regulations, the way to handle salvage value is to estimate it at the time you buy the asset, then subtract the estimate from the object's purchase price before figuring the annual depreciation. But salvage value is a hard thing to estimate in advance. So, as a practical matter, many tax experts advise you to forget about it until you actually get salvage money, then treat this amount as a long-term capital gain.

What happens when you trade in an old asset on a new one? To illus-



*"Yes, I know you took out my husband's appendix a year ago.
But this is my second husband."*

rate, let's assume that you drive your \$3,200 Buick only two years before you decide it's time for a change. Assume that you've been using the declining-balance method of depreciation. You've therefore claimed \$2,400 in depreciation already; your undepreciated balance amounts to \$800.

Those Trade-Ins

Now, a car dealer offers you a \$1,400 trade-in allowance on your old car. This leaves you \$600 ahead on paper. For depreciation purposes, therefore, you'll have to subtract that \$600 from the purchase price of the new car. So if you buy another \$3,200 Buick, you'll have to figure depreciation on it starting from \$2,600.

In these days of liberal trade-in allowances, you'll quite often get more than your car's undepreciated balance. But it's also possible to get less—in which case you stand to benefit tax-wise. Here's how:

Suppose your car is damaged in a wreck. When you trade it in after two years, you're allowed only \$400 for it. Yet its undepreciated balance is still \$800. So you add the difference—\$400—to the \$3,200 price of the new car, getting a figure of \$3,600 from which to figure depreciation. Of course that means a more liberal write-off each year.

How Many Years?

Now let's turn to an important part of the depreciation story that

the new tax law *hasn't* changed: estimating how long your capital assets can be expected to last.

Barring unusual circumstances, you'll do well to follow the Government's estimates on this. Here are some of the more important estimates of useful lives considered normal by the Internal Revenue Service:

Automobile	3 to 5 years
Bookcase	20 years
Cabinet or file	15 years
Desk	20 years
Diathermy unit	10 years
Dictation machine	6 years
Fan or room air conditioner	10 years
Lamp	10 years
Linoleum	8 years
Locker	25 years
Mirror	20 years
Rug, carpet, or mat	10 years
Safe	50 years
Settee	13 years
Surgical equipment	10 years
Typewriter	5 years
Water cooler	10 years
X-ray machine	10 years

If listing your equipment piece by piece complicates your depreciation records too much, you can lump together assets of a similar nature. These assets don't have to be the same age; that is, you needn't have bought them all in the same year. Nor must they have identical useful lives. And there's no limit to the number you can include in any such group.

[MORE→]

As a doctor, you're allowed to lump practically all your professional assets into five main groups: (1) buildings; (2) safes; (3) scientific equipment; (4) mechanical equipment; and (5) furniture, fixtures, and filing cases.

The life of a building depends, of course, on its construction. But the four other groups of assets have useful lives recognized by the Internal Revenue Service as follows:

Safes	50 years
Scientific equipment ..	10 years
Mechanical equipment .	8 years
Furniture, fixtures, and	
filing cases	15 years

Whether you lump your equipment into groups or list each piece by itself, your depreciation records are likely to be more complicated during the next few years. To take advantage of the new provisions for faster write-offs, you'll naturally have to segregate equipment bought

since Jan. 1, 1954 from your old assets.

Remember, too, that the Government's useful-life estimates are *only* estimates. If some of your equipment has been subjected to unusually hard wear (and if you can prove it), you're entitled to a faster write-off. In rare cases, you may even be allowed to claim full depreciation on a capital asset that's less than a year old. (This could happen, for example, if the introduction of a new type of equipment made your old type suddenly obsolete.)

As a rule, though, you'll find it advisable to follow the Government's estimates of useful life pretty closely. The reward for an abnormally fast write-off would seem mighty small if, as a direct result, your returns for the last three years were subjected to a detailed, time-consuming audit. And nowhere in the new tax law is there any hint that the Treasury men will change their inquisitive natures.

END

Position Is Everything

- After each delivery, an OB man I know jots the essential facts about the case on a slip of paper, then asks his secretary to transfer them to the patient's record. After he'd hired a new office girl recently, he gave her such a slip to dispose of. Later, in checking over the records, he found the following neatly typed: *Patient: Mrs. Lee. Race: Oriental. Sex of child: Twin boys. Names: Roa and Loa.*

—REGINA GIRARD, R.N.

Murphy Is a Drip

Plenty of doctors give their names to syndromes, tests, or diseases. Semantically speaking, the result is an eponym. Medically speaking, it's just plain confusing, as this humorist points out

By Justin Dorgeloh, M.D.

● Eponyms are as spicy to medical parlance as sand traps to a golf course, and often just as deadly. To be sure, few doctors now expect a speedy Quick test; and none but a layman would choose the Drinker apparatus for a tipsy brother-in-law. Such transparent traps are obviously for mere duffers. So let's shift our attention to veritable quicksands which threaten even the low-handicap physician.

Lest the reader not realize the magnitude of the problem from the start, I submit three examples for immediate consideration: (1) Head's zones can be mapped out over most of the body, not just the head. (2) Frog, rat, and rabbit tests notwithstanding, the Magpie test (for mercury) requires no magpies, and the Eagle test (for syphilis) uses no eagles. (3) Patella's disease (pyloric stenosis in TB patients) was named by or for a Dr. Vincenzo Patella, who perhaps refrained from ever mentioning patellas on principle.

On the other hand, it's entirely possible to play around a verbal sand trap that doesn't exist. When word of the rice diet was first whispered about in hospital corridors, I lightly assumed that, whatever the diet was, it must be the brain-child of some Dr. Rice. Dr. Augustus Rice

MURPHY IS A DRIP

somewhat came to mind (though I have never heard of anybody named Augustus Rice). It was finally pointed out to me, gently, that the rice diet is simply a diet of rice.

Possibly I muffed this one because Patella's disease had tattooed my diencephalon, because I'd learned that the quite sippable Sippy diet was named after Dr. Sippy, and because at an early age I had to be set straight on the Diet of Worms.

Milkman's Matinee

I soon afterward sliced into a medical sand trap that *did* exist. One memorable morning, our hospital radiologist pointed to some X-ray portraits of bone streaks and murmured, "Milkman's syndrome." I still remember the scene vividly, for a respectful hush immediately settled upon the little group of doctors present. (More enigmatic than the face behind a poker hand is the cautious physician face-to-face with a challenging eponym.) Unable to fathom whether "Milkman's syndrome" was an everyday term among my strangely silent colleagues, I happily remembered an autopsy I hadn't finished, and propelled myself to the hospital morgue.

During the following weeks, I turned over the "Milkman" question at length, usually while trying to fall asleep at night and invariably when no medical dictionary was closer at hand than roughly two miles. First off, was "Milkman's syndrome" just

a hoax, an offhand fabrication tossed out as bait by our fun-loving radiologist? Hardly, since the maneuver would have been a dangerous one for any job-loving radiologist beset by creditors.

Next came the inevitable question: Does the malady plague milkmen, or does it refer to a doctor named Milkman? As far as recent experience went, Patella's disease and the rice diet pointed in opposite directions. The streaks of calcium (or lack of calcium) in the bones irresistibly suggested a relationship to milk—and hence to milkmen (who, for all I know, wouldn't be caught dead with a glass of milk). Consideration of the many bona fide occupational diseases, such as woolsorters' disease, pearl-workers' disease, shuttlemaker's disease, and brass founders' ague, finally lulled me into thinking of Milkman's syndrome as vibrational lines of stress in the bones of milkmen (a natural result of incessantly rattling milk bottles to arouse sleepy-headed customers in the wee hours of the morning).

Doctor From Scranton

Then one day I happened across M.S. (Milkman's syndrome) in my medical dictionary. I discovered that the bone lesions bear no more relationship to milkmen than Baker's cyst to the bread industry. It so happens that the syndrome *does* bear a relationship to Dr. Louis Arthur Milkman, of Scranton, Pa.

At this juncture, I would gladly

have ascribed the "coin lesions" of chest-film X-rays to anybody named Dr. Coin. But the common-noun nature of the term was explained to me straight off.

The chest surgeons' unquestioning acceptance of this potential slur is a source of wonderment to me, for it is only a matter of time before some non-chest surgeon snidely paraphrases mass-survey coin lesions as "pennies from Heaven." Forsooth, the "coins" of today are but the "balls" of yesteryear: cannon balls, tennis balls, ping pong balls. (Of course, "ping pong ball" became obsolete as a figure of speech after medical science succeeded in stuffing *real* ping pong balls into human chest cages. Medicine's is a dynamic, ever-changing tongue.)

Austin Flint and Graham Steell murmurs are patently named after human beings.* The irony here is that each first name sounds like a last name; and I tend to think of the murmurs as Austin "flint" and Graham "steel" (especially since the minerals tie in well with a Water hammer pulse).

Hyphen Trouble

The double-name nomenclature finally sows the seeds of its own destruction by way of the hyphen. Unfortunately, the human ear cannot distinguish a silent hyphen from

*However, the genus and species of a proper name cannot be assumed in all instances. For example, the three strains of poliomyelitis virus are named after a human patient, an American city, and an ape named Brushilde.

a slight impediment of speech. For example: Paul-Bunnell could well be Paul Q. Bunnell, if he (or they) were not as a matter of fact two men tied together by infectious mononucleosis and a hyphen. On the other hand, "Graham Steell" sounds hyphenated, and could be misinterpreted as indicating Dr. Graham and Dr. Steell.

Even the *printed* hyphen is not foolproof. Pel-Ebstein and Smith-Petersen add up to three people, and you've got one name left over.

Another tidbit for the troubled mind is the matter of multiple references. Loeffler's bacillus cannot cause Loeffler's syndrome, and any conjunction of Addison's disease and Addisonian anemia is sheer coincidence. Nothnagel's syndrome, seat-



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MURPHY IS A DRIP

ed in the brain, is definitely unrelated to Nothnagel's bodies, encamped in the feces.

Speaking of bodies, did you ever contemplate a Wolffian body catching up with a Jolly body? Probably end up in Room 606 of Charcot's joint.

Possibly the worst all-round troublemaker in medical terminology is the name Weber. It pops up in such unrelated maladies as Weber's disease,^{*} Sturge-Weber disease, Weber-Christian disease, and Rendu-Osler-Weber disease. It also lends itself to Weber's law, Weber's paradox, Weber's corpuscles, Weber's glands, Weber's organ, Weber's point, Weber's triangle, and Weber's douche. Furthermore, there are three distinct Weber tests, by either two or three Webers.

As a matter of fact, seven Webers are entangled in the fifteen items listed above: Theodore, Moritz Ignatz, Ernst Heinrich, Eduard Wilhelm, Sir Herman, Friedrich Eugen, and "F.P." Incidentally, "Weber" is pronounced differently depending on which Weber you're talking about (assuming that you know).

The name of Friedrich Daniel von Recklinghausen was destined to link two totally unrelated diseases,[†] but it is doubtful that he or anyone else foresaw how this bit of whimsy would eventually lead to utter con-

^{*}Also known as the Weber-Gubler syndrome, Gubler's paralysis, and the syndrome of Weber.

[†]There is also a third von Recklinghausen disease: "neoplastic arthritis deformans." For the sake of clarity, this entity will not be introduced into the text.

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fusion. To start slowly, von Recklinghausen's neurofibromatosis is, of course, no more related to von Recklinghausen's osteitis fibrosa cystica (hyperparathyroidism) than hallux valgus is to athlete's foot. But someone dubbed von Recklinghausen's bone disease "osteitis fibrosa cystica generalisata" (so that it could more easily be confused with the totally unrelated osteitis fibrosa cystica disseminata).

Now hold tight: Word has got around that osteitis fibrosa cystica disseminata (*not* to be confused with osteitis fibrosa cystica generalisata, or von Recklinghausen's disease) is very possibly a manifestation of neurofibromatosis (von Recklinghausen's disease).

The Weber-Nothnagel-von Recklinghausen class of sand traps should clearly be retained for diversionment in medical conversations. Just say: "Are you referring to *Sir Herman* Weber?" and you'll probably have your adversary over a barrel.

However, the proper noun-common noun trap is another matter entirely. A short perusal of any metropolitan telephone directory will show what this class of eponyms can lead to. Future medical students may well have to cope with the Pickle diet, the Doolittle treatment, Longenecker's palpitation, the Gorley operation, the Flatt-Foote syndrome, or the Loos-Love curet.

I say it's high time hazards like these were ruled off the fairway. END

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They're Raising a New Crop Of Country Doctors

Illinois M.D.s and farmers have linked arms to solve a problem of the soil: replenishing the state's limited supply of rural physicians

By Mauri Edwards

- It's unlikely that Burton Bagby would have become a country doctor—or any other kind of doctor—without outside financial backing. Luckily, he got that backing, through a loan program run jointly by Illinois physicians and farmers.

He had always wanted to study medicine. As a boy in cotton-raising Pulaski County, in Southern Illinois, he'd made the rounds with his uncle, a country doctor. He had even got through his premedical studies.

But then the depression hit his family; and an expensive medical education was out of the question. Despite this setback, young Bagby never forgot his ambition. He worked for a time as a hospital orderly in Long Island, N. Y., and he served in a mobile hospital unit overseas during World War II.

After the war, he sat down one day and took stock of himself. The future didn't look too bright.

True, he'd beaten about the fringes of medicine quite a bit. But it seemed certain that he had missed his main chance. He was already over 30, married, with three children—and no savings.

Yet today, 40-year-old Burton Bagby has his medi-

NEW CROP OF COUNTRY DOCTORS

cal degree (Loyola, 1952) and a steadily growing farm-area practice. While he was helped along by his own determination and by the G.I. bill of rights, he got his medical education chiefly because the doctors and farmers who had set up the Illinois scholarship plan in the late Forties felt that Bagby had the makings of a good rural physician. So they took a \$5,000 chance on him.

Their investment seems to be paying off. Dr. Bagby now has nine months of practice under his belt in doctor-poor Pulaski County. "And I'm home to stay," he says.

Why He's Grateful

With good reason. He knows and likes Pulaski's people. He gets along well with the two other doctors who practice in the area around Mounds, his home town. And he enjoys his work.

He also enjoys his home ("It's Mother's old house; she moved in with my brother to make room for us"); a fourth child ("our third girl"); and a neat, three-room office ("in the business section, a good location"). He's on the staff of St. Mary's Hospital in near-by Cairo ("I do their anesthesia work three days a week").

His practice is developing nicely ("I've already done about ten maternity cases, and I have others scheduled"). His collections are high, even though most of his patients are poor ("One nice thing about poor patients is that they don't

look for specialist care, so I can do more for them"). And, thanks to a rising income, Bagby has even invested in a 1954 Chevrolet.

Surveying his prospects, he expects to have little trouble repaying his loan to the farmer-doctor fund. "I'm eager to repay it," he says. "Out of gratitude, if for no other reason."

Burton Bagby is one of fifty-two Illinois men who have been helped by the fund. Most of the others are still in medical school or serving in the Armed Forces, or interning. Three have flunked out.

Only Burton Bagby and one other fund beneficiary (32-year-old Donald Lee Hartrich, now located in Jasper County) have fulfilled the purpose of the fund by entering rural practice. But six others will make their debuts this fall and more are expected to follow suit.

Like his Pulaski County colleague, Dr. Hartrich plans to stay put. He feels at home among the wheat and soybean farmers of Southeastern Illinois. And they've taken to him, too.

Finding replacements for aging rural practitioners is not a new problem. But it wasn't until after World War II that Illinois doctors and farmers found the time ripe to attack it. Much of the spadework was done by a committee of physicians sparked by Harlan English, a soil-bred Danville urologist.

"We knew there was no shortage of farm boys studying medicine,"

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he says. "The trouble was, they weren't carting their knowledge back to the farm. They were marrying blondes in Chicago and staying there. As a result, we've got a thousand doctors too many in Chicago and not nearly enough in the country.

"But don't misunderstand me. You can't just transplant big-city doctors. They wouldn't know what the farm people were talking about."

How It Began

The thing to do, the English committee decided, was to turn farm boys into doctors—and then make sure they returned to the farm by getting agreements from them in writing. The 10,000-doctor Illinois State Medical Society liked the idea; so did the Illinois Agricultural Association (made up of 200,000 farm families). So, in 1948, the two organizations jointly created a student loan fund—each contributing \$50,000 and three directors.*

These six men review all loan applications. In their zeal to find a potential doctor for a forgotten back area, they may sometimes accept a candidate whose academic average is unspectacular. But they inevitably weed out those who, in Dr. English's words, "lack a willingness to work and an intense interest in rural life."

He adds: "Naturally, we may

*Along with Dr. English, who serves as chairman, the doctor-directors are Edwin L. Hamilton of Kankakee (a farm boy turned A.M.A. trustee) and Everett P. Coleman of Canton (a country doctor's country-doctor son).

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*Cook, M. H.; Free, A. H., and Giordano, A. S.: Am. J. M. Technol. 19:283, 1953.

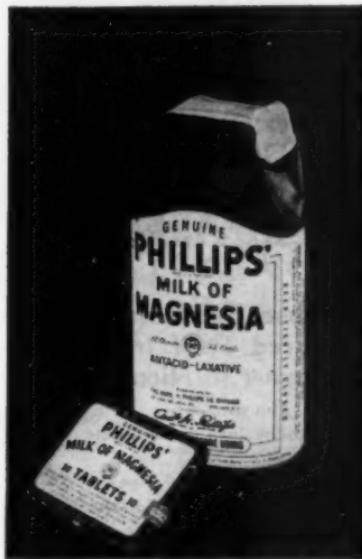
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make mistakes, but we try to reject those applicants who aren't real farm boys and who don't seem to have what it takes to make good doctors. I say to the others on the committee, 'Can you conceive of calling this man out to take care of you or your wife?' That's the acid test."

In one intensive, eight-hour session in Chicago each spring, the board puts about twenty-five applicants through Dr. English's acid test and accepts the ten likeliest young men. While those who pass muster may attend any accredited medical school, most of them enter the University of Illinois College of Medicine.

The simple reason: The university sets aside ten places in each class for the loan-fund borrowers. And it generally accepts all who pass the board's final screening.

Since a doctor-farmer loan is practically an open sesame to the school, the loan board gets applications from many young men who don't need financial help but whose grades couldn't normally get them into medical school. If the directors accept any such candidate, he's given a token loan of \$1.

But whether an applicant receives \$1, \$2,000, \$3,000, or a full \$5,000 loan, he must agree to practice in the countryside for at least five years.

Loans granted by the directors are paid out in annual installments. Meanwhile, the board takes out an insurance policy on the young man's

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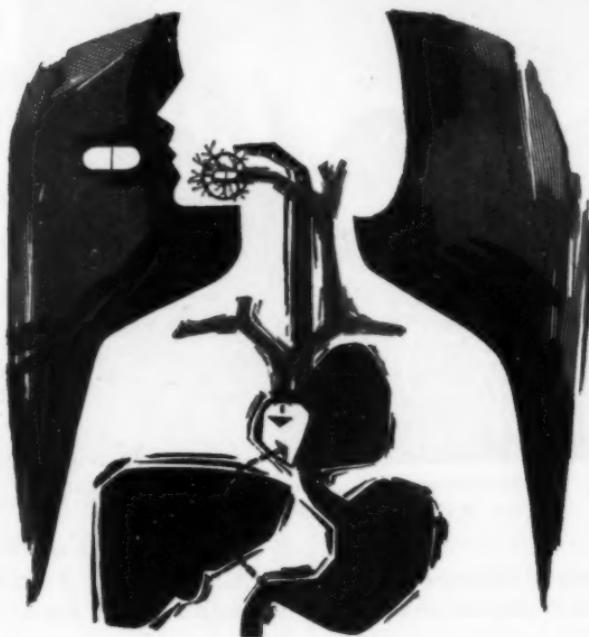
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NEW CROP OF COUNTRY DOCTORS

life—just in case. And he signs a contract to pay back the loan, at 2 per cent interest, over the five years that he promises to spend in a specified rural area.

Sometimes, of course, a newly made doctor may try to renege on part or all of his contract. One interne, for example, recently pleaded with the board to let him practice in his bride's home town—a somewhat larger community than the road junction he had signed up for.

"His wife's town needs another doctor like a dog needs two tails," growls Dr. English. "We told him that he might have made a mistake picking his wife, but he's damn sure going where he promised to."

Suppose a doctor simply breaks his pledge to settle down in a farm area. "Then," says Dr. English, "he finds that he's signed an exceedingly binding contract." The interest rate jumps from 2 per cent to 7 per cent—and the pay-off must be made *at once*.

'Tough Old Men'

There's been one such case. A graduate was offered an attractive berth in Florida, so he skipped out on his promise to practice in rural Illinois (and to pay back the loan). The directors' retribution was swift and sure:

They notified the young doctor's county society. It dropped him from its membership rolls, cutting him off

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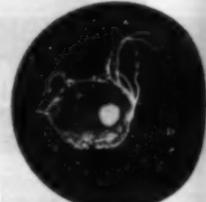
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from his hospital privileges. He paid up—interest and all.

"We're tough old men," says Harlan English, with a smile. "We have to be."

\$100,000 More

So far, the directors have carefully invested about \$85,000 in future farm physicians. They're hoping to raise an additional \$100,000, so that the program can be continued at full tilt, while the early loans are being repaid.

Eventually, of course, the plan will be self-sustaining. With this in mind, the medical and agricultural associations meet the program's administrative costs and charge up nothing to the fund. Similarly, no charge is made for such other activities as putting the student borrowers

on display at various functions of the two parent organizations.

"It's a little like parading ponies at the race track," says Dr. English, in referring to the way the young people are exhibited. "But it's important—especially to the farmers. They're the real consumers of this program, and they figure correctly that they have dough riding on the students' noses. Naturally, they like to see what they're betting on."

Frankly, the whole program is still considered something of a gamble. "We're betting that after five years in a farming area, a doctor won't want to pick up and go," Dr. English explains. "I think that 95 per cent of these boys will stay in pastoral practice. I know there's no other place where they could be economically so well off." END

Straight Dope

• None of our hospital staff had been able to classify the confusing epileptic seizures presented by one of the ward patients. So when we were honored by a visit from a neurologist of world renown, we jumped at the chance of getting some first-rate diagnostic assistance.

The great man graciously consented to examine the patient; and, by a lucky chance, one of the seizures occurred during the examination. We of the local staff held our breaths as, watching every move of both patient and doctor, we awaited the famous neurologist's diagnosis.

Finally it came. The doctor pursed his lips, coughed briefly, and spoke.

"Looks like a fit to me," he said.

—MARVIN L. THOMPSON, M.D.

Do You Scare 'em to Death?

Strange-looking instruments and double-edged medical terms can give your patients a bad time

By Henry A. Davidson, M.D.

• A good many of us are so accustomed to the paraphernalia of practice and the nomenclature of disease that we forget how these things can frighten patients. Our offices abound with needles, scissors, and knives; we toss off words like "tuberculosis" and "cancer" without batting an eye. They're simply part of the day's work.

But the patient isn't conditioned to them. Too often he comes to the office harboring a fear of being hurt or a fear of being told something devastating.

Nothing deteriorates a doctor's practice and prestige faster than a reputation for scaring people. Another doctor's cystoscopy may be no more painful than yours; but if you know how to handle the procedure with finesse, the patient *thinks* the cystoscopy is less painful—or at least approaches it with less dread.

Fear often begins with the sight of a shelf full of instruments behind a glass door. To the patient, they may look like something out of Torquemada's private locker.

The moral? Don't display the scalpels and the curettes, the needles and the lancets. Tuck them away behind an opaque door.

Fear recurs when you recommend some test or procedure that sounds formidable. Sure, *you* know that an X-ray or a basal metabolism is about as painful as a haircut. But does your patient know it? From his viewpoint, the metabolism machine may look like a man from Mars;

D. IN TENSION AND HYPERTENSION

Serpasil

C I B A

DO YOU SCARE 'EM TO DEATH?

the X-ray machine, like something left over from the latest H-bomb test.

Time to Tell All

The housewife who often pricks her finger while sewing may still be in mortal fear of a blood count. She may think it means carving a trench in her arm and pumping out the blood. Sounds ridiculous, but can we assume she knows a blood count means only a finger prick? Somebody ought to tell her. And that somebody is none other than her family doctor.

When it comes to fear, the small-fry patient is, of course, in a class by himself. Luckily, the technique of assuaging childish alarm has been

well worked out. Most doctors are acquainted with it, need only a firm determination to try it.

The well-informed general practitioner, for example, knows how to set up his office so that it looks cozy to the child; how to offer lollipops and comic books; how to let the youngster fool around with the flashlight and look down the doctor's throat first; how to compare instruments with homely and familiar objects (the X-ray is a camera; the stethoscope, a telephone).

Sometimes fear rides on the very words we use. Tell the mother that her child has a "concussion" and she may conjure up an image of broken skull-bones and subsequent idiocy. That word, along with a few others,

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had best be kept on the taboo list.

Fear is sometimes generated more by our attitude than by our words. Utter the slightest "tsk, tsk" as you listen to the patient's heart and none of your reassuring words later will carry any conviction.

Fear is engendered alike by cold aloofness and by overdone sympathy. But fear melts when you seem pleasantly interested, act and speak with firm assurance, radiate a positive confidence in the correctness of your diagnosis, and show optimism about the outcome.

Down deep, you may not honestly feel that optimism. But when ministering to the sick and the troubled, you've got to appear to be the pillar of strength they need.

Nor is this just for show. In a large proportion of patients, fear is an emotional drain that worsens their condition. Alleviation of fear, therefore, becomes a genuine therapeutic tool.

When the patient feels a positive assurance that he's in safe hands, the solace he gets does something to his blood pressure, his heart rate, his stomach chemistry, his intestinal motility. Psychosomatic studies have long indicated the role that emotional relief plays in healing organic diseases.

When there is no chance of recovery, what is your position then? Take the patient with metastasized cancer who asks in pathetic and frightened eagerness, "Doctor, is it

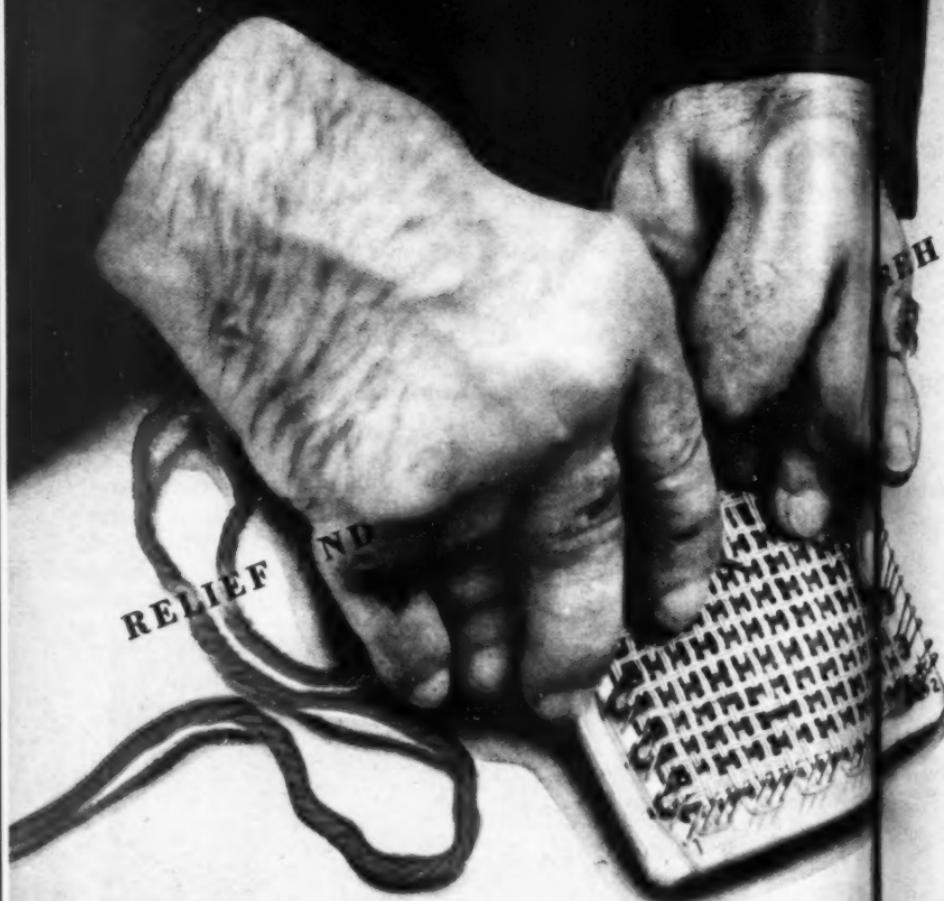
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cancer?" Since neither publicity nor improved control methods have yet cleansed that word of its burden of despair, it seems certain you will be forgiven for saying something other than "Yes."

Mum Is the Word

The responsible member of the family must of course be told. But, except in rare instances, little good is accomplished by telling the pa-

tient. Let it be an "ulcerous condition," or "an infection," or anything except the word that is still considered a warrant of death.

What you need in all your patients is a cheerful willingness to co-operate. In some of them, you need much more—a positive, fighting spirit. All this may be wiped out if fear gets loose in your office. You, through your own words and actions, can keep it bottled up. END



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Choosing a Location: The Office Site

These resettlement experiences of other medical men may help guide you in your selection of the most desirable neighborhood and building

By Paul Lowell

● "I knew where I wanted to move my practice, all right—the section of the country, even the town. The tough part was selecting the best spot for my office."

That comment is typical of dozens made to MEDICAL ECONOMICS in response to a nation-wide survey of physicians who've resettled. Most such men agree that the final step in choosing a location—finding a good office site—is probably the most vital of all.

In previous articles, this magazine has covered the steps leading up to the selection of an office. Now, what about this final problem?

Considering its importance, you might think that nearly all doctors on the move took special pains about selecting their new spot. Yet this doesn't seem to be the case. Dozens of relocated physicians say they merely grabbed

*This article is the last of a series on "Choosing a Location." Earlier installments were subtitled "The Basic Factors" (November, 1953); "How to Get Leads" (January, 1954); "What Part of the Country?" (February, 1954); and "How to Judge a Community" (March, 1954). Material has been drawn from many sources—among them, the A.M.A. Physicians' Placement Service, the directors of state and local medical society placement programs, and a survey by MEDICAL ECONOMICS of several hundred doctors who have relocated in recent years.

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CHOOSING A LOCATION

the first available site. Many do that they've come to repent the hasty.

For an example, consider the story of a 40-year-old G.P. who not long ago moved from Chicago to a medium-sized Southern city:

A friend put him onto a "good deal"—a low-rent office over a drug store. It was cramped; it was dark; it was poorly laid out. But it was immediately available—and it cost only \$50 a month. So he didn't hesitate to move in.

Gradually, this physician managed to build up a fair-sized practice. But he was unhappy; and he leaped at the chance—a year later—to share a five-room suite with another doctor. When he moved across town, however, less than two-thirds of his carefully built-up practice followed him. It was another year before his income caught up again.

The Steps to Take

What does this story prove? Simply that it's important to choose a good office location the *first* time.

All right, then. But how to go about it?

1. *Pick your neighborhood with an eye to its future—and yours.*

"The specialist hangs his shingle in the heart of town," the old axiom goes; "the family doctor sets up practice in a residential section." Respondents to our survey indicate that there's still a lot of truth in this ancient rule of thumb. (With at least this one notable exception: The postwar growth of suburbs has been

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CHOOSING A LOCATION

such that more and more specialists—especially obstetricians and pediatricians—have been moving outside the cities.*

Look Ahead!

Whatever kind of neighborhood you choose, don't overlook its future prospects. One physician who's now in California concedes that he'd probably still be back in Illinois except for one thing: He picked his spot with an eye on the past when he first went into practice in an old Chicago suburb.

The section looked good to him; it was filled with massive mansions, and he took its future for granted. So he bought a \$35,000 home and spent \$10,000 attaching an office to it. Then he waited for his practice to boom.

It never did. Trouble was, the old families were dying out. Their white-elephant mansions soon became rooming houses. Since transient roomers made poor patients, the doctor finally had to move—and sell his own big house at a sacrifice.

"I'm happy in California," he says. "And I'm reasonably sure that my practice will grow here. Before I bought my present office, I tried to make a study of what this section will be like in ten years. I liked what I was able to find out."

One key to the future of a neighborhood is often found in local zoning laws. For example, a gastroenterologist who resettled in the

*See "Shopping Center Practice Is Here to Stay" (September, 1954).



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1. Slepyan, A. H. (1952) Arch. Dermat. & Syph., 65:228, February.

2. Slinger, W. N. and Hubbard, D. M. (1951) *ibid.*, 64:41, July.

3. Sauer, G. C. (1952) J. Missouri, M. A., 49:911, November.



AFTER TREATMENT—patient applied SELSUN twice a week for first two weeks, once a week for the next two weeks. Then followed a lapse in treatment. Note that scalp is still scale-free two weeks after last treatment.

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CHOOSING A LOCATION

Northwest tells us he backed out of the first deal offered him there. He had learned that weak zoning laws might permit a small factory to take over some neighboring acreage.

Zoning laws can also affect your choice of neighborhood in another way. One Missouri physician bought an expensive home in a highly desirable community and proceeded to add an office to it. Came the surprise climax: He was ordered to stop practicing medicine there. The courts ruled that local restrictions barring business from operating in the area barred professional practice as well.

2. *Pick the site that's most convenient for most patients—and for you.*

Accessibility to hospitals can be an overriding factor. "I saw one office site that had everything," says a Southwestern surgeon. "But I didn't even consider it. It was twenty-seven miles away from the nearest hospital."

Wrong Side of Tracks

Distance from hospitals isn't always the whole story. Four Michigan medical men found their office inconvenient simply because they had to cross busy railroad tracks to get to their hospital. Repeatedly, on rush calls, they were held up at the grade crossing while a hundred-car freight train lumbered by. Eventually, this medics foursome felt obliged to move to the "right" side of the tracks.

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C I B A

CHOOSING A LOCATION

well, there are still men who overlook it. A Colorado physician tells how he built a charming office on a beautiful acre, tucked in an out-of-the-way mountain area. What drew him to the spot was the fine trout stream. Trouble is, he now has more fish than patients.

Accessibility usually means a location near public transportation. A New Jersey gynecologist tells of the mistake he made in assuming that all his patients would arrive by car. He recently moved into a new medical building on a major highway—a location not served by any bus line.

Unfortunately, most of his patients are from one-car families; and the husbands use the car to drive to

work. So many of his patients are unable to get to his office until after dinner at night.

"If I could do it over again," this night-owl M.D. says now, "I'd make sure my office was handy to a bus stop."

Room for Cars

Probably the sine qua non of a good office site these days is ample parking space. "I had a choice of two locations," says a Southern California dermatologist. "One was in a pleasant but crowded neighborhood, cramped for parking room. The other, in a less attractive area, had lots of curb space for cars. My choice was easy: I took the place with the parking space." [MORE→]

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This point of view is heartily seconded by an orthopedic surgeon in Maryland. He thought his original location was good, but he'd overlooked a severe parking problem. And, of course, easy parking was essential to his patients, since most were incapacitated and thus largely dependent on their cars. "I'm doing better now," this man reports. "My new location has a small parking lot nearby, and I've arranged free parking there for my patients."

3. Pick your spot after taking into account the location of other doctors.

A young pediatrician recently moved to Texas. In the town he selected to practice in there were two other men in his specialty—one on

the north side, the other on the west side. The new man found office space on the *southeast* side—also a residential district.

He Reduced Competition

"Obviously," he said, "there wasn't much point in my locating close to the other two pediatricians. By going into a different neighborhood, I naturally built a practice among people who live closer to me than to the other men."

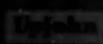
Of course, this can be carried too far. A Midwestern psychiatrist reports that he chose his original location largely because there was no other psychiatrist anywhere around. He soon found himself with more work than he could handle—and



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CHOOSING A LOCATION

without opportunity to consult fellow psychiatrists.

"When I moved," he says, "I made sure I wouldn't dig myself right back into professional isolationism."

Thus, the opportunity to work closely with colleagues may be more important to you than the avoidance of competition from them. A relocating heart specialist in the South reports: "The best thing about my present set-up is that I'm in a professional building—surrounded by other doctors. This means more referrals, sure. But that's not all. I practice in a kind of medical-center atmosphere that's wonderfully stimulating to me."

4. Be prepared to pass up some desirable office features for the sake of an ideal location.

Probably every doctor would like a modern, ground-floor office on the best corner in town. A Manhattan internist describes such an ideal set-up: "My office signs catch the eyes of passers-by not only on Park Avenue but on the side street, too. In addition, my patients needn't use the main lobby of the building. I have a private entrance."

Walk-Up Problem

But what if you can't get an ideal location? Then the closest thing to it may be your best bet—even if it's on an upper floor. This, however, does not apply to a Pennsylvania ophthalmologist, who sacrificed a little too much to be near the best corner. His second-story office is ac-

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CHOOSING A LOCATION

cessible only by a steep flight of stairs. Every so often, a departing patient—with eyes still blinking and watering—will miss the top step on the way down.

As a rule, doctors seem willing to sacrifice a few comforts for a superior location. These quotes from our survey illustrate the point:

Location Comes First

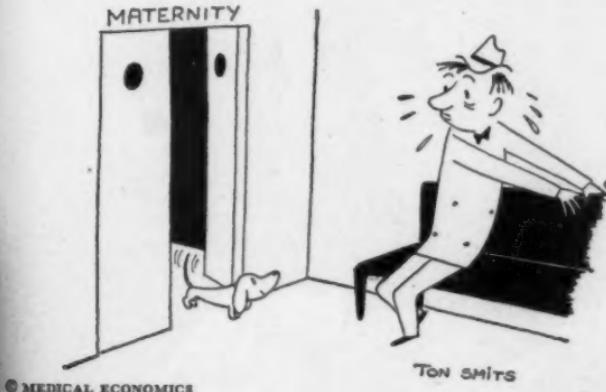
"I didn't mind that I was moving into a relatively small office," says a young G.P. who's just starting out in Connecticut after a hitch in the Army. "All that really counts is that there's room here to expand later, when my practice grows. And it should grow, because I'm in the best-located building in town."

"It didn't bother me that the building I moved into was a little old," says a pediatrician new to Alabama. "I just made sure that the

wiring was up-to-date, so I could air-condition the place. At least the building is ideally situated."

Occasionally a doctor will forgo nearly *all* desirable features in an office—including some location features emphasized here—and the place will still turn out all right. It may reassure you to know about a 31-year-old G.P. in Kansas. His office is old, the neighborhood poor. He's far from a hospital. There's not much parking space.

"You see," he says, "I took over the practice of a beloved old man who'd been practicing here fifty years. The old fellow's office is hardly a dream set-up, but I wouldn't *think* of changing it—beyond making a few minor modifications. My patients are familiar with this office. It has pleasant associations for them. I simply *have* to practice here—and I'm doing all right, thank you." END



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How Much Security Is Enough?

At what point should government call a halt to its responsibility for a man's welfare? Social legislation will surely be overextended unless this question is answered, the author declares

By Ray D. Murphy

• Much of my experience over the years has been gained in helping Americans to achieve a degree of personal security on a voluntary basis. But, like many life insurance men, I have given a great deal of thought to the influence of government welfare measures.

I cannot hope to discuss all such measures here. So I shall use the Federal Old Age and Survivors Insurance system (O.A.S.I.) as the focal point of my comments. It will serve as an illustration of more general problems, such as Federal health insurance.

Mankind has always sought some form of security to a greater or lesser degree. And it always will seek it.

The desire for security is basically good. It can breed foresight and an eagerness to save and to become a self-reliant citizen.

On the other hand, most persons have been deeply influenced by the incentive of opportunity to improve their lot, even at some risk. This incentive, as a matter of fact,

Mr. MURPHY is president of The Equitable Life Assurance Society of the United States. This article is drawn from a recent speech to the National Industrial Conference Board.

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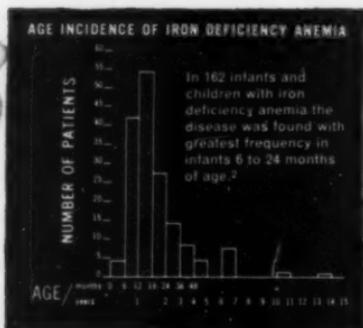


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1. Wintrobe, M. M.: *Clinical Hematology*, ed. 3, Philadelphia, Lea & Febiger, 1951, pp. 642-643.
2. Smith, H. J., and Rosello, S.: *J. Clin. Nutrition* 1: 275, 1953.
3. Jeans, P.C., in *A.M.A. Handbook of Nutrition*, ed. 2, New York, Blakiston, 1951, p. 280.



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HOW MUCH SECURITY IS ENOUGH?

has created most of our heroes, from ancient times down to the present. It has stimulated imagination, creativity, and courage. It has generated some of the greatest advances in civilization and in our standard of living.

So it is not my purpose to criticize either of these motives—whether the seeking of security or the seeking of opportunity. Each has its place. But unless a proper balance is maintained between them, an excess of one or the other can produce serious evils.

The predominant influence during the Nineteenth Century in the United States came from the seeking of opportunity. Now, in the Twentieth Century, the balance is changing. The seeking of security has come to the forefront; and the emphasis on opportunity has tended somewhat to diminish.

The Dangers of Both

In these circumstances, we would do well to stop and take stock. We know that in the last century measures had to be taken to curb the unbridled pursuit of opportunity. Anti-trust laws, conservation laws, and prohibitions against the exploitation of child labor were among the results.

Let us now consider the dangers that may beset us if we put too great emphasis on the pursuit of security. In ancient Rome, and many times since, modest social relief measures were adopted by governments to

help cure unrest and increase political stability. But, as so often happens when political expediency is the keynote, one step led to another until there was no stopping place. And what started originally as modest relief of poverty turned into a method of substantial redistribution of wealth.

Many a Rome has fallen in consequence.

Why has this tale been repeated so often? One reason may be that a beneficence once enjoyed at the expense of others comes to be looked upon as a right. Then, demands for increased support from the same source are stimulated by the ordinary weaknesses of human nature. At the same time, those who provide the increased benefits find themselves enjoying progressively fewer of the fruits of their labor and initiative; hence, they lose their incentive to create and produce.

In guarding the public of today against undue hardship, voluntary insurance has performed a notable service. It avoids the compulsion of governmental measures. It gives the individual free choice to suit his security to his own needs and desires. It relies in large measure on savings rather than on taxation.

In addition, it avoids forcing one man to provide another man's security. Finally, it serves both the person who seeks opportunity and the person who seeks security.

Despite the advantages of voluntary insurance over government so-

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HOW MUCH SECURITY?

cial security, it's understandable why old age benefits were provided by Congress in 1935. The great depression of the Thirties had shown the difficulty many wage earners encounter when they try—especially during economic hard times—to provide for their old age. The time had come, the public apparently felt, to put the problem on Uncle Sam's doorstep.

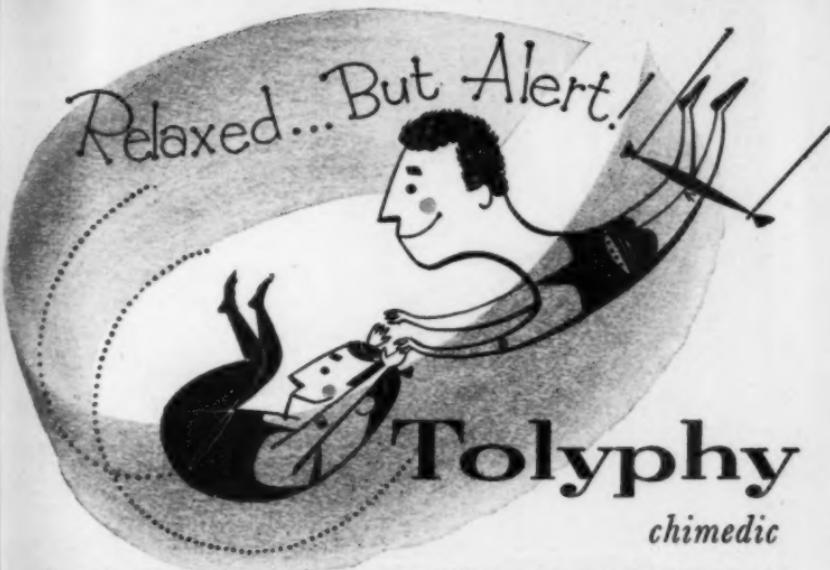
Now that the plan is in operation—and is clearly here to stay—a basic question arises:

How far should this system go in providing benefits? For how much of a man's security should government take responsibility? The most cogent answer I have seen comes from the pen of Lord Beveridge, who wrote:

"To give by compulsory insurance more than is needed for subsistence is an unnecessary interference with individual responsibilities."

We cannot consider old age benefits by themselves. They are part and parcel of our whole economy. If that economy leads to an inflation that depreciates the dollar, then dollar payments for old age benefits won't be enough to furnish subsistence. If, on the other hand, old age benefits are pushed too high, they can themselves be the cause of a higher price level.

One of the great dangers is that it's politically attractive to emphasize the expectation of increased benefits in the future rather than to stress the increased taxes that will



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- to relieve pain, increase mobility, restore muscle strength and function.

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J.A.M.A. 140:572
(June 23) 1949

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be needed to pay for those benefits. This is the easier to do because the rise in the tax rate is considerably deferred and because the full weight of increased benefits is therefore also deferred. Yet, in the end, the Government can have no benefits to give except from the taxes it takes.

The tax rate has already risen to 4 per cent (2 per cent each from employer and employee); and even with no further increase in benefits, it can readily climb in time to 8 per cent, or even 10 per cent. The actual top figure will depend, of course, on such factors as wage levels, employment conditions, longevity, incentives to the elderly to retire, and so on.

I repeat, then, as Lord Beveridge has urged, that benefits should be confined to the subsistence level. Let us not attempt to include any benefit that can and should be provided by private pension plans, by individual savings, or by relief measures for the needy, who are best cared for locally by municipalities and states.

O.A.S.I. Analyzed

A number of serious misconceptions about O.A.S.I. need to be corrected. For example:

The American people have not yet come to realize fully that "more can be given," as Lord Beveridge has said, "only by taking more." The nation simply does not get something for nothing in Social Security.

It's generally assumed, too, that

Social Security taxes are a form of savings, that they're stored up to guarantee future benefits. In view of this, it's no wonder that when, say, an older beneficiary (upon payment of \$150 in taxes, supplemented by \$150 paid in by his employer) gets old age payments totaling \$15,000, he says: "Social Security sure is a bargain!"

He hasn't stopped to think that the remaining \$14,700 must come, in one way or another, from his fellow citizens. On the contrary, he's likely to say, "Let's have more of this fine, cheap insurance."

It Isn't Insurance

Incidentally, such use of the word "insurance" is thoroughly objectionable to those in the insurance business. The word "insurance" suggests an individual equity relationship that simply doesn't exist in O.A.S.I. Nor is O.A.S.I. based on commonly accepted insurance principles.

The mistaken impression that O.A.S.I. taxes are insurance premiums or savings has doubtless misled many persons into thinking that the Government has sufficient money stored up to meet the benefits that will become payable in the future from wage credits already acquired. The uninitiated, when told that the O.A.S.I. Trust Fund holds some \$19 billion in government bonds, may find their belief strengthened even further.

Little do they realize that some



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HOW MUCH SECURITY IS ENOUGH?

\$200 billion would be needed at the present time to cover the accrued liabilities of the Social Security system!

Essentially, the O.A.S.I. is operating on a pay-as-you-go basis, with a moderate contingency fund available to act as a buffer to cover any temporary excess of benefit payments over tax receipts—an excess such as might occur in a business recession. Under this system, the active workers and their employers are subsidizing their inactive neighbors on the benefit rolls. By the same token, the active workers themselves will eventually have to look for *their* old age benefits, not to the Trust Fund primarily, but to the taxpayers of the next generation.

Changes in Order

Now, what of the moves taken so far, or proposed, to amend O.A.S.I.? I will first mention two that I believe to be quite sound:

First, there's the extension of O.A.S.I. to several million not previously covered. This, in my view, is reasonable and desirable if the social purposes of the plan are accepted at all. Injustices develop if part of the nation's working force is under the system and part is excluded. Similarly, the efficiency of O.A.S.I. is impaired if large numbers of persons are continually moving into and out of the system as they change from job to job.

Another change that seems reasonable concerns the O.A.S.I. retire-

ment test—the so-called "work clause." Some kind of work clause is absolutely necessary if Social Security funds are not to be dissipated in providing needless benefits to persons in regular employment. But the work clause should not interfere with casual employment or induce people to withdraw from the labor market. It should be to the individual's advantage to continue to be productive and to increase his income as much as he can after age 65.

There are unsound proposals, too. I'll mention only a couple of them:

Most dangerous, I believe, is the idea of raising benefits above the subsistence, or floor-of-protection, level. I also have serious misgivings about the idea of taking account, for benefit and tax purposes, of earnings up to \$4,200 a year instead of \$3,600 a year.

A Summing Up

In conclusion, let me sum up in three short points:

1. We have been moving into an age of renewed emphasis on security-seeking through governmental means—a trend that, if carried to an extreme, can be highly dangerous to our whole economy.

2. Most of the dangers of excessive security-seeking can be avoided if the role of government as the security-provider is minimized, and if voluntary savings and insurance are relied on as much as possible as the means to security. [MORE→

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Dihydrocodeinone bitartrate*	1.33 mg.
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¹ Bonyai, A. L.: Management of Cough in Daily Practice. J.A.M.A., 148:501, Feb. 16, 1952.

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HOW MUCH SECURITY IS ENOUGH?

3. For these and other reasons, Social Security benefits should be maintained at a modest floor-of-protection level.

We Americans are a generous people. We won't put the aged, widows, and dependent children on

starvation rations. At the same time, we have enough good sense so that we won't cut down the living standards of self-supporting people in order to shower excessive, unneeded, or incentive-destroying benefits on those who are dependent. END

Sculptor in Wood



Though a practicing radiologist, Dr. Sol Fineman of New York City spends his off-duty hours doing surgery—on old trees. During vacations, he tours the forests of New England with saw and hatchet, looking for fallen timber. He lops off interesting branches and roots, then takes them home for shaping and polishing. Eventually they wind up in his office as examples of abstract art. Here he tightens a screw on the stand of his prize-winning wooden statue, "Bird in Flight."

Thirteen Hints on Heating

Want to cut your fuel bill? Put real efficiency into your heating system? Here's the way a heating engineer would tell you to do it

By Edwin N. Perrin

• Since World War II, there's been a revolution in the heating industry. From the pre-war coal furnace, builders have switched to shoebox-size gas and oil burners. The old steam radiator has given way to radiant panels. Outside thermostats and zoned heating have brought savings in fuel that many doctors still haven't heard about.

Below you'll find thirteen practical suggestions. We'll start with the ones you could put to work for you now:

Zone your heating system. To do this, you simply add a second (or third) thermostat, plus special valve controls in your piping. Each thermostat then governs a separate part of your heating system—and regulates the warmth in a separate "zone" of your house.

You can, for example, have one thermostat for bedrooms, another for living areas. If you have a home-office, you can install a third one to control the temperature in your professional suite.

Zoned heating has two big advantages: fuel saving and temperature stability. With only one thermostat, you're apt to be cold in one room, hot in another. The reason, of course, is that a room with a southern exposure (or a fireplace) needs a lot less heat than rooms chilled by the

*While these hints have been drawn from many sources, the editors are particularly grateful to two prominent consulting engineers: Alfred L. Jaros Jr. and Walter L. Fleisher, both of New York.

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1. Susinno, A. M., and Verdon, R. E.: J.A.M.A. 154:239 (Jan. 16) 1954.
2. Rottino, A.: Journal Lancet 71:237, 1951.
3. Pelner, L., and Waldman, S.: New York State J. Med. 52:1774 (July 15) 1952.

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north wind. With its own thermostat, it gets less heat.

Consider an outdoor thermostat. These devices have been called "anticipators," because their job is to turn up the heat *before* you start to get cold.

Here's the theory: During a sudden cold snap, an indoor thermostat won't start your furnace until the air temperature inside your house begins to fall. But meanwhile, the walls and windows chill rapidly, as much as an hour or two before the air temperature drops. Result: you feel cold.

An outdoor thermostat, on the other hand, gets the furnace going as soon as the cold snap sets in, thus preventing any heat lag. (Similarly, it will "anticipate" a sudden spell of warm weather and turn the furnace off—thus cutting down fuel consumption.)

Use radiant panels in cold nooks. As a supplement to your regular heating system, you can put radiant glass panels in any spot where you need a limited amount of extra warmth (e.g., a bathroom, a basement workshop, a drafty dressing room).

These panels are inexpensive and efficient. They can be installed right in the wall. The heat radiates outward from aluminum strips fused in the glass.

Radiant glass panels work on regular electric current, and that's apt

to be far more expensive than coal, oil, or gas. So as a full-time heating device, they may not be for you. But as a supplemental source of heat—as on a winter sun porch that's closed off most of the time—they're generally well worth their operating cost.

Look into driveway snow melters. If your approaches tend to get snow-bound, you can have heat pipes laid under your driveway and front walk. Hot antifreeze or a specially stabilized oil can then be circulated through the pipes. Result: snow removal without shoveling.

For this installation, your driveway must be paved. If the pipes should ever get stopped up or spring a leak, it could be pretty costly digging them up again for repairs. But today's welded-joint steel pipes are designed not to leak; and a removable filter installed where you can get at it will keep the system from clogging.

Replace old-fashioned radiators with baseboard piping. The hot-water radiator is the most efficient heat source ever designed, in the opinion of more than one expert. But it's ugly; it takes up valuable space; it creates problems in furniture arrangement—particularly if rooms are small.

The baseboard radiator, on the other hand, takes up almost no room at all. It's a continuous strip of metal (7" high, 2" deep) designed to re-

HINTS ON HEATING

place your wooden baseboards. Warm water flows through pipes set in the metal, providing floor-level radiant heat around the perimeter of each room.

Take advantage of solar heat.

This means installing enough extra windows to flood your house with sunlight in winter. It may also mean installing permanent metal awnings on south windows, so as to keep the place shaded during the summer.

Such awnings can be placed to admit all rays of the low-altitude winter sun, while still blocking off high-angle summer sunshine. Once in place, they require no putting up or taking down. And, being above the window, they don't interfere with the view.

Don't overlook spot insulation.

Probably your house came equipped with wall insulation, perhaps in the form of rock-wool stuffing. But even after your walls are protected, there are plenty of places where your house can lose its heat. Windows, for example. Besides the familiar weather-stripping and storm windows, you might well consider sealed casings and twin-pane windows.

Other forms of spot insulation are available. One of the most efficient is a single layer of metallic paper tacked on the attic ceiling. (Even more efficient is an accordion-pleated double layer made to fasten between studs.) If the metallic paper is metal-coated on both sides, it will

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Action:

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2. Prompt, prolonged neutralization of excess gastric acidity... magnesium oxide and aluminum hydroxide.
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Bentyl Hydrochloride 5 mg.
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Dosage:

Gel — 2 to 4 teaspoonfuls every three hours, or as needed.

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ence on the gastric mucosa and muscularis.² It is specifically and directly beneficial in control of motion sickness.

Dosage: Sedative-antispasmodic, 0.25 Gm. 2 to 4 times daily. Nausea or Motion Sickness: 0.25 Gm., repeated in 30 minutes if necessary. Hypnosis: 0.5-1.0 Gm., ½ to 1 hour before retiring.

Contraindicated only in severe cardiac, hepatic or renal disease.

CLOTRAN is supplied in golden-orange, soft gelatin capsules, 0.25 Gm. (3/4 Gr.) and 0.5 Gm. (7 1/2 Gr.); bottles of 100.

1. Beckman, H. *Treatment in General Practice* (Saunders) 1948. 2. Krantz, J. C. & Carr, C.J.: *The Pharmacologic Principles of Medical Practice* (Williams & Wilkins) 1951.

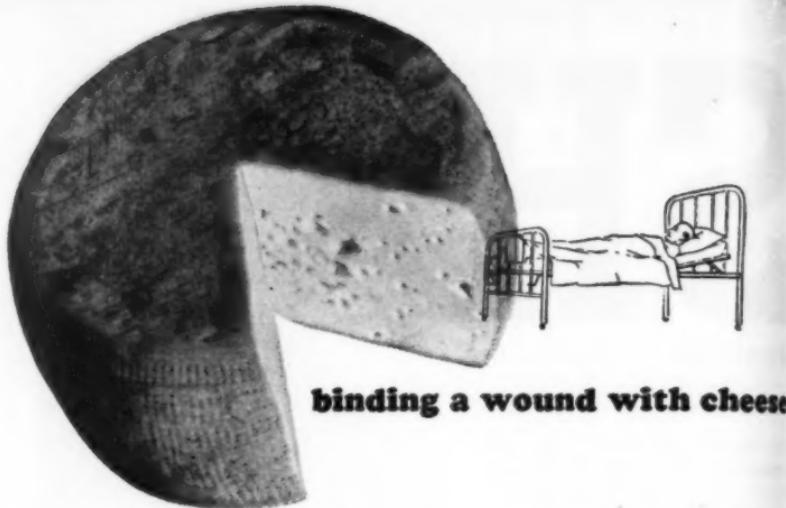


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The wide variety of Borden cheeses lends itself to a diversified diet—from main dishes based upon popular Cheddar and Swiss or refreshing salads with soft Cottage or Cream cheese—to epicurean Camembert or Lieder-kranz Brand that add a tangy finish to the meal.

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THIRTEEN HINTS ON HEATING

turn back summer heat as well as hold in winter warmth. It can be hidden under composition board, or left in the open. Best of all, it's cheap and easy to put up.

Look carefully into radiant heat. Of all the new ideas in heat control, radiant heating is perhaps the most popular with builders. A typical radiant set-up consists of a standard furnace supplying hot water to a network of copper pipes embedded in the walls or in the floor (not recommended) or concealed under an aluminum or plaster ceiling.

This kind of heat means no drafts, no cold floors, no currents of hot air. Because the warmth is uniform, you're usually comfortable at a rather low temperature (65° F. or less). Naturally, therefore, you save considerably on fuel.

The only real disadvantage of radiant heating is that it's difficult to combine with air conditioning. So if you live in an area where summers are humid and small auxiliary air conditioners aren't adequate, you'll want to think twice before making the change.

Go slow on radiant floors. When you discuss radiant heating with a contractor, he'll generally urge you to bury your heating pipes in a concrete slab floor. He has good reason, too: Such floors are easy to install.

But in actual practice, radiant floors present these difficulties:

1. You can't heat a floor to much

more than 90° F. Above that temperature, the floor becomes uncomfortable to walk on; and some floor coverings begin to deteriorate.

2. If you do try to heat your house with a floor temperature of 90° , you may not be able to keep the place warm enough on really cold days.

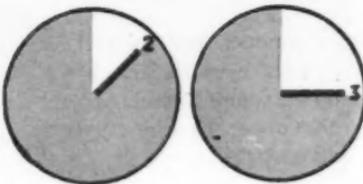
3. If you design radiant floors to be used with rugs, then take up the rugs later, you'll upset the system. And vice versa. (Moths are another factor: In rugs laid over heated floors, they're said to breed faster.)

Consider investing in radiant ceilings. Heating engineers favor this system above most others. You can heat a ceiling to about 110° , so there's plenty of heat even on cold days. And since heat rays travel in straight lines, they'll keep your rugs as pleasantly warm as a radiant floor would—without any likelihood of damage.

The best type of radiant ceiling employs copper or galvanized steel piping under sheets of perforated aluminum. This can be painted to match any décor, and it will seldom need refinishing. You can expect the initial cost to be 10 or 20 per cent greater than that of a radiant floor. But you'll make up the difference in more efficient operation.

Choose your fuel for reasons besides cost. In most areas, coal is still the cheapest source of heat. Yet outside the mine districts today, few

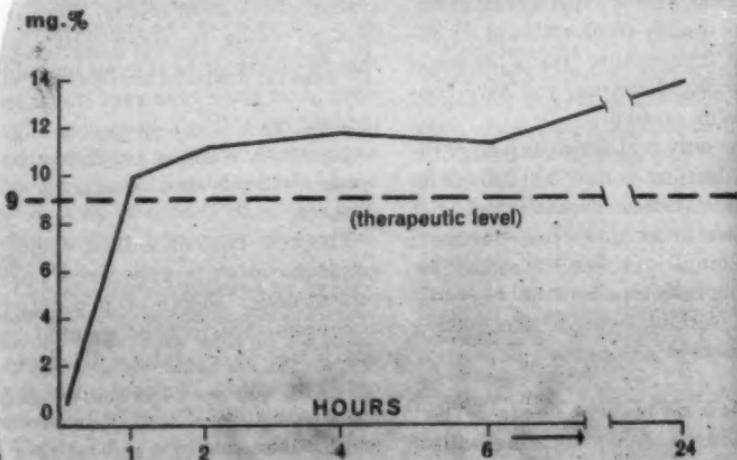
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THIRTEEN HINTS ON HEATING

people ever build a house with a coal furnace. Instead, about two-thirds of new home-owners select gas heat; almost one-third choose oil.

The reason, of course, is that coal is too much bother. First you have to store it; then you need a fair-sized furnace to burn it; and finally you have to get rid of the ashes.

Of the more popular fuels, oil is generally the cheapest—often little more expensive than coal. But oil, too, must be stored; and an oil furnace must generally be put in a separate furnace room.

So it may be that gas heat is your best bet. It's often more expensive than oil, but makes up in added convenience. You can install a gas furnace in a closet on the first floor, or suspend it from the ceiling of a utility room. And you don't have to store gas.

As for electricity: It's clean, convenient, and about eight times as expensive as gas (except in cheap power areas like the Tennessee Valley). In general, electricity is practical as a full-time source of heat only in the few places where it costs less than 1½ cents per kilowatt hour.

Consider year-round heat control. If you now have a forced-warm-air heating system, you can adapt it fairly easily for winter *and* summer air conditioning. It doesn't matter whether your present furnace is gas, oil, or coal; the new conditioners will work in almost any house that contains air ducts.

Typically, the unit consists of two boxes, each the size of a small refrigerator. They stand next to your furnace. The winter conditioner cleans and humidifies; the summer conditioner cools and dehumidifies. Both operate on a relatively small amount of electricity.

Because it serves the dual purpose of heating and cooling, this combined system doesn't do either job as efficiently as a single purpose unit might. Ideally, cold-air ducts should be high on the wall; heating ducts should be down at floor level. With the same ducts for both systems, therefore, you're bound to waste some fuel (although double-glazed windows will keep the loss to a minimum).

But this flaw is generally outweighed by the fact that you're assured a comfortable temperature and well-humidified air for twelve months of the year. Many people are reportedly converting to the dual system.

Don't go for the heat pump just yet. In another ten years, perhaps, heat pumps will virtually replace the home furnace. So, at least, think leaders at Westinghouse, General Electric, and a dozen other big companies—and they are backing their prediction with millions of dollars in research and development funds. But most current models have severe limitations.

The heat pump works like a giant refrigerator that reverses itself in

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For the average doctor, therefore, the heat pump is still impractical. But in a few years it may be his best buy.

END

Anecdotes

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Methylcellulose	200 mg.
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I Joined the Human Race

By Frank Perry, M.D., as told to Alberta Williams

AN IMPORTANT TREND in medicine since World War II has been the slow but steady obliteration of the profession's color line. Back in 1939, there were only about 350 Negroes studying medicine; and only 13 per cent of these were enrolled in "white" schools. Today, by contrast, more than 700 Negroes are studying medicine, at least 25 per cent of them at such schools.

This trend in medical schooling reflects the trend in the profession at large. Even in the South, the Negro physician is gaining acceptance. Not long ago, the Medical Society of the District of Columbia dropped its ban against colored doctors. In such states as Alabama, Kentucky, and Tennessee, county medical societies have opened their doors to Negro members.

But can doctors of both races work closely together without friction? A recent Saturday Evening Post article* answers this question with a resounding "Yes." In the Deep South, where he was born, Dr. Frank Perry learned what it's like to be an American Negro. Today, at Memorial Hospital in New York City, he's learning what it's like to be accepted by white colleagues.

Because his article lights up the practical problems that more hospital staffs may soon face—and because his story is a rewarding human document besides—we reprint it here, by special permission, as a service to doctors everywhere.

● My belongings were put away in the room I'd share with Dr. Oliver Renaud, another of the seventeen incoming July, 1952, residents starting special training in cancer surgery at Memorial Center for Cancer and Allied Diseases. I wanted to be out when he arrived. I placed the photographs of Clara, my wife, and of little Clara and Tony, our babies, on my bureau. From these, if he felt that way, Renaud could raise objections and, with me not there, there'd still be no openly unpleasant incident at the beginning.

[MORE→]

* Copyrighted, 1954, by the Curtis Publishing Company.

I JOINED THE HUMAN RACE

This was my first time in New York, and I was eager to see more of it than the glimpse I'd caught between Pennsylvania Station and Memorial. But to start out alone immediately to explore the strange city struck me as too aggressive for the tactfully tentative mood I felt I should preserve.

I wanted to acquaint myself with every inch of the units comprising the center—Memorial Hospital, where I had my appointment; James Ewing Hospital, a municipal hospital staffed and operated by the center; Kate Depew Strang Cancer Prevention Clinic; Tower Clinic, and the Sloan-Kettering Institute for Cancer Research. I knew I had a perfect right to saunter round and look at everything, but wouldn't that be starting things in a rather conspicuously bold manner?

I ventured to the staff lounge. It was deserted and I sat down to watch a television program. Soon a resident in hospital whites came in. He smiled and introduced himself. "I see you're colored," he observed. "Where are you from and where'd you go to school and get your training in general surgery?"

I was so totally unprepared for his candor that I barely managed to say I was from Lake Charles, Louisiana, had gone to Xavier University, in New Orleans, and Meharry Medical College, in Nashville, Tennessee, and had taken four years of surgery at Meharry's Hubbard Hospital.

"Well, I'll be damned!" he ejacu-

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lated. "I'm from Wyoming, but I served a residency in New Orleans and I know how they treat Negroes. I don't see how you ever stuck it. How did you get up here?"

When my father had taught us children how to be Negroes, he'd been emphatic in his advice about necessary dealings or conversation with a white person. "Put on your Sunday manners. Be short. Be quick. And get away fast!" I clammed up cautiously, murmured a few carefully polite generalities, said I had a letter to write and went back to my room.

I hadn't been there long when Renaud came. He was a friendly, good-looking Chicagoan who met me without surprise or special scrupu-

tiny. To my "Doctor Renaud," he said, "I'm always called Tim." When I admitted I'd seen practically nothing of the center he said, "Let's get going and prowl."

To me, Tim's manner and attitude were as new and interesting as the wonderful facilities and equipment we were seeing. I could tell he wasn't being nice to me just because I was a Negro. That's something I never miss. Nor did he ignore the fact. He said, "I've never been in the South. I've never before lived with a Negro, but I've always had colored classmates."

The first third-year resident we came across and with whom Tim started getting acquainted was Donald Martin, who had gone to

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I JOINED THE HUMAN RACE

med school at Vanderbilt, in Nashville. I was silent until Martin started asking me questions. Answering them was uncomfortable. But I'd come to live and work three years with these white doctors and I knew I'd have to stop trying to get away fast.

The Money Problem

When Martin learned I had no funds except the ninety-dollars-a-month first-year resident's pay, he said, "I'm no millionaire, but if you run out of money I can let you have some." Then he briefed me helpfully on T-17, the admitting service where I'd work the following morning.

Next he began telling me about Memorial's nursery school. "It's co-

operative—run by the parents, house-staff people—but the hospital furnishes the quarters, and the auxiliary makes up the operating deficit. There are three salaried, professional teachers. Tuition's based strictly on the parents' income. My kids go there. Your little girl's old enough to start, and I hope you'll send her this fall, and your boy as soon as he reaches the age."

In our med-school days in the same city Martin could have had no association with me. But now he was calmly suggesting that our children should be playmates in nursery school! I was puzzled.

Tim and I joined a whole group of new residents. They'd gone to the famous schools—Harvard, Colum-

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*Chick, H.: *Nutrition* 7:59, 1953; Cotereau, H. et al.: *Nature* 161:557, 1948.

Jolliffe, N. et al.: *Clinical Nutrition*; Hoeber, New York, 1950; pp. 586-601.

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bia, Johns Hopkins—and they'd had five or six years of surgery in the big hospitals. Arriving at Memorial was for them a natural progression. The one thing I wanted to say over and over was how wonderful it was to be there. I was awkward and inarticulate when their questions showed an interest in how a Southern Negro lands in a Northern prestige hospital. I couldn't talk much with them. I'd never discussed racial problems with white people.

Now I can talk about it all. Not just because I've grown accustomed to frankness, but because my experiences here have brought about a complete reversal in my own attitude. It's of this reversal that I want most to tell; it has convinced me

that a Negro's resentment against white people cannot last when he is allowed to join them in common work and earnest purpose. I wish my story were typical. It isn't. But it's what happened to me and it is, therefore, what can happen.

My father, today seventy-three and no longer working, was a rice-mill hand who never earned more than twenty dollars a week and who, during the depression years, got most of his pay in the sacks of rice without which we six children would have gone hungry. He can read some, but he can barely write his name. Mother, who died seven years ago, had little more education. Ours was a devoutly Catholic home, and as a boy I served the priest at

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1. Gagliani, J., et al.: Internat. Rec. Med. & Gen. Pract. Clin. 107:251, 1954. 2. Grossman, A. J., et al.: Internat. Rec. Med. & Gen. Pract. Clin. 107:263, 1954. 3. Batterman, R. C., et al.: Internat. Rec. Med. & Gen. Pract. Clin. 107:261, 1954.



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I JOINED THE HUMAN RACE

Mass and received Communion daily. My parents never gave us the idea that any ambitions we had were hopeless because we were black. They taught us not to wait for the lowering of all barriers against our race, but to go ahead and take advantage of all opportunities open to us.

Not one of us ever spent a day in a nonsegregated school, but all of us finished college. Harold, the oldest, a priest of the Society of the Divine Word, serves a rural-Louisiana parish; Thelma, now living in Washington, before her marriage taught school three years, then went to Howard for graduate work and became secretary of Howard's department of economics; Fred is a den-

tist in Berkeley, California; James is a dental student at Howard; Verlie is a Government secretary in Washington. To get any education, we all had to win scholarships to cover tuition, and earn money with which to defray our other expenses.

When I entered Sacred Heart Parochial High School, I had for two years been Father Hannigan's houseboy in return for my good meals and my own room in the rectory. Then the white priest said to me, "I'm going to start paying you two dollars a week. Do you want the money in cash or in the bank?"

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cian. I knew nothing of medical-aptitude tests—six years later, fortunately, I ranked high in one—or the urgent need for colored doctors. Even today there's one white physician for every 720 of the population, but only one colored doctor for every 3500 Negroes. My incentive was my consuming desire to achieve a life where I could have good standing in a Northern colored community and be isolated from and independent of white people.

I scraped together money for a radio-repair correspondence course advertised in a magazine, and pored over the lessons when I was supposed to be working in the rectory's outer reaches. When I finished the course, I set up a back-porch shop.

For the first time I learned that I was good with my hands—a fundamental requirement for the surgery of which I wasn't then even dreaming. Between my houseboy and radio-repair earnings I had \$1000 when I was graduated from high school.

In our parish, to go to college was to go to Xavier, conducted by the same order of white nuns who have our mission school. We did not know even the names of the great institutions of learning in other parts of the country. My marks in high school landed me a scholarship at Xavier.

Arriving there, I had a sudden sense of freedom and protection. New Orleans seemed magnificent, the college campus and buildings

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large and beautiful. I found an exhilarating liberty in the way we students would endlessly discuss the racial question.

White Music

But soon I began to see that my sense of security and freedom was false. When I left the school's segregated safety and walked along streets where there were white pedestrians, I had to make my way in fear; if I brushed against a white person and was not quick enough and obsequious enough in my apologies, a fight might start.

Another disconcerting thing began to dawn on me. We students were fanatically prejudiced, so that we judged the merit of things as

Negroes. We were enthusiastic over Duke Ellington and Count Basie, whose music was in what we considered a colored style, but were thumbs down on Noble Sissle, a colored orchestra leader who we thought had a white style.

I contrasted our charged verbalizing with the unbroken silence the faculty maintained on racial relations. At Xavier the faculty handled the racial problem by ignoring it. I found this unrealistic attitude thoroughly disillusioning and decided that the race situation was utterly hopeless, that I couldn't even find out much about it. I dropped out of the student bull sessions, put all my energies into studying for the straight "A" marks that would make



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me certain of admission to medical school, and into earning the money for my first year as a medical student.

From there on, my trip to Memorial was made the way a Southern colored boy who was poor would have to, but could, make it. I swept the walks, cleaned the toilets, carried the restaurant trays, held the summer-vacation jobs that enabled me to leave Xavier with \$900 of the \$1000 I'd brought there with me. I got the straight "A's" and was admitted to Meharry.

Black World

At Meharry I was among Negroes I could admire and respect; and the school and Hubbard, its teaching

hospital, were so much a world in themselves that I was still more cut off from contact with white people than at home or in New Orleans. My money saw me through the first year, and my financial problem was solved when the Army took over at Meharry in the fall of 1943, the start of my second year, and soon I was Pfc. Frank Perry, with eighty dollars a month and all expenses paid.

Upon graduation from Meharry I got a rotating internship at Hubbard. On the surgical phase of this service I found I'd hit the field in medicine that interested me most. Dr. Matthew Walker, the big, forthright, but kind, man and truly fine surgeon who heads the department of surgery at Meharry and Hubbard,

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Bradley, J. E., et al.: J. Pediat. 38:41, Jan., 1951.



1953

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Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. 65:311, Feb., 1953.



1954

Recently reported "...particularly suitable for industrial dispensary practice, as well as for office and hospital treatment." Authors stress "safety, simplicity, economy..."

Tebrock, H. E., and Fisher, M. M.: N. Y. Times 82:271, April, 1954.

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Levenstein, I.: Report of Lebarco Laboratories, Roselle Park, N. J.

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I JOINED THE HUMAN RACE

thought I had ability in the field and asked me to stay on for a five-year surgical residency. I was keen to specialize in surgery, but I was chafing to get out of the South and into the prosperous independence of a general practice. I couldn't even consider voluntarily sentencing myself to another five years in the corral.

My brother Fred finished his dental course at Howard just as I completed my internship, and the two of us opened an office in Stockton, California, which then had a colored population of about 5000 and was without a colored dentist or doctor. We had busy practices right from the start. I had a good income; one month my practice made me \$2000. At first I was childishly elated. I was where I didn't have to trot out phony deference for every contact with a white man. I wasn't dependent on white people for anything. My courteous manners toward them were spontaneous, not obligatory. I had equality before the law. I could go where I pleased.

Nine-Month Practice

I kept reminding myself of all this when a disquietude began to grow within me. Patients who required surgery or hospitalization I had to refer to a local white doctor or send to San Francisco; I hadn't surgical training and I had no place on the attending staff of the local hospital. Gradually I had to admit to myself that I'd have no deeply rewarding satisfaction in this world until I'd

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... would be required to equal the 25 mg. thiamine content of a single capsule of "BEMINAL" FORTE with VITAMIN C, which also contains therapeutic amounts of other essential B factors and ascorbic acid as follows:

Thiamine mononitrate (B₁) 25.0 mg.

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put myself in a position to use the best ability I had in medicine. After nine months of general practice in California I felt compelled to return to Meharry and segregation, and learn surgery. I could take another slug of Jim Crowism only because I knew I could again leave the South when I was trained in surgery.

I'd saved enough in my California months to see me comfortably through Hubbard's surgical residency, which paid seventy-five dollars a month. I didn't feel that I couldn't afford marriage when I fell in love with Clara Compton, a pretty, soft-voiced Nashville girl who was a graduate of Fisk and who worked in the office of Hubbard's treasurer. We were married in April

of 1948. Little Clara was born in January, 1950, and Tony was born the following year.

As I progressed, the work under Doctor Walker was fascinating—particularly the cancer cases. They were such a challenge to the very best we could do! I started reading everything I could get hold of on cancer and was amazed at how great a special field cancer surgery was becoming. I read about operations that made me hopefully excited—work in bone cancer, radical neck dissections, pneumonectomies, hepatic lobectomies, laryngectomies. Doctor Walker supplied a sympathetic ear for my high interest.

The day after Dr. Allen O. Whipple, then in charge of surgical serv-

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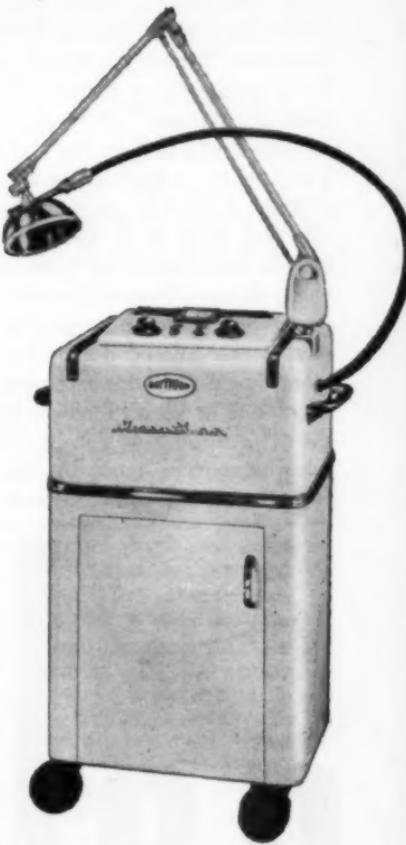
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I JOINED THE HUMAN RACE

ices at Memorial, came to Meharry and addressed us, Doctor Walker called me into the office and said he'd talked with Doctor Whipple about me. "I think you should apply for a residency at Memorial," my chief advised me.

Clara and I talked over the idea. I wanted to go into cancer surgery, all right, but I had never wanted to live and work with white people. But in all colored medicine there was just one Memorial-trained surgeon. Surely more were needed. And if one colored doctor had got along successfully for three years at Memorial, it seemed cowardly for me to be afraid to face it. But would my treatment be markedly different from that of the white doctors? Did

a colored doctor get admitted over the objections of a good many of the attending staff, so that he must be forever careful in contacts with the dissenters? In the confident expectation of a good income when I finished my training at Hubbard, we'd used up my California savings. We hadn't money. We didn't know how or where we'd live or how we'd get along in New York.

"If you get accepted, we'll manage somehow," Clara insisted. "Go ahead and put in an application."

Hello, New York

The weeks went by and I had no response to my application. We stopped trying to picture how a New York life would be. I'd been

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Pleasant-tasting antacid adsorbent for prompt, lasting relief of gastric hyperacidity or management of peptic ulcer . . . without constipating effects.

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Arobon is simply prepared: The powder is merely stirred into milk or water, forming a highly palatable drink. Suggested doses: for children and adults, 1 to 2 level tablespoonfuls in milk or water; for infants, 2 to 4 level teaspoonfuls boiled in water.

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jars and is available
through all pharmacies.*



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I JOINED THE HUMAN RACE

turned down. I knew it. But after three months, on the last Wednesday in June, the telegram came. Could I arrive at Memorial on Sunday and be ready for duty Monday?

And that is how I got here. To me, what has happened since I came is more important: I have ceased being just a Negro and have joined the human race. In it I know the only true freedom—freedom of the spirit. This did not come until I could easily give and easily receive. The giving was not hard to achieve. But at first I could not really receive; I could only take in incredulous bewilderment. Easy receiving grew from many influences, incidents and affirmations.

First Class at Last

First, there was the undeniable certainty that I was at last in a place that is first-class. Heretofore I had been connected with only colored institutions, and their segregation alone places them as, at best, second-class. The training here is a rich professional experience; our chiefs, our attendings and our junior attendings are fine and generous teachers, and we on the house staff get a wealth of interesting work to do. This year I took and passed the examinations of the American Board of Surgery, so that now I am certified to practice my specialty.

The second big environmental factor influencing me was Memorial's pervading purpose. Here everybody—doctors, nurses, technicians, researchers, the entire staff—works



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TRIPLE SULFONAMIDES

to increase antibacterial range and reduce resistance . . .

Three strengths:
125M, 250M, 500M

Each tablet contains:

Penicillin G Potassium, Crystalline
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Scored tablets in bottles of 50.
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against one appalling evil. The singleness of our aim generates a tremendous sense of solidarity that I could not fail to assimilate. No isolation or apartness was possible in my work.

Many Negro Patients

My first morning at Memorial I was surprised and pleased to find that a good many Negroes are here. I was the only colored doctor—since then another came as a radiology resident—but there were colored nurses, technicians and secretaries as well as porters, cleaning women and orderlies.

In the clinic were several colored patients. They flashed me the look no white man could have seen and that said, "It's good to see one of us is a doctor here." Perhaps they were the reason Memorial had a place for a colored doctor—he was supposed to take the colored patients? But when work began, we took the patients just as they came, with no sorting out at all. I thought some colored patient might go to the desk and ask if he could have me for his doctor. None ever has. Today I'm as glad about this as I am that no white patient ever asked not to have me.

Why Don't They Object?

But I couldn't unquestioningly receive acceptance by these white patients. I kept looking for a reason behind it. Why didn't they object to me? I sought the answer in Memorial's reputation. Memorial was good and the patients thought that I,



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Gram-positive cocci . . .

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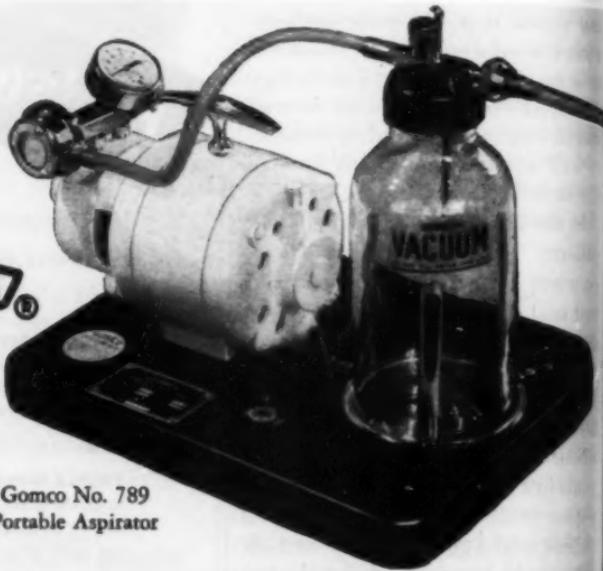
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extra features we include for this reason. We *know* users want aspirators that won't be spending time in repair shop—that will last indefinitely—that will be convenient and efficient and quiet in use.

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therefore, must be a good doctor. No, that couldn't be exactly it; if a colored doctor suddenly appeared in one of the South's best hospitals his acceptance by white patients would not be without incident.

I tried another line. Many of the clinic patients were foreign-born, and I'd once heard a Southern white man say, "Foreigners don't know any better than to treat niggers as equals." I searched for a difference in the manner of foreign-born and American-born patients. There wasn't any.

No-Fee Cases

Money, then; that had to be it. These clinic patients couldn't afford the fees for private care and they had to take what they could get and put up with it. When I served my turn on private service, attending surgeons would feel obliged to ask me to avoid contact with certain patients.

Although I couldn't readily receive the white patients' acceptance of me, I had no trouble talking to them. I examined a man of fifty who had inoperable carcinoma of the stomach. His case hit me as especially tragic, because he was still hopeful and turned to me as though to a great specialist to ask what we could do to save him. I found myself clinging to a fond and foolish hope that I could help him. I couldn't have been more involved with a patient and his trouble at Hubbard. We were two helpless humans together. I had never before spontane-

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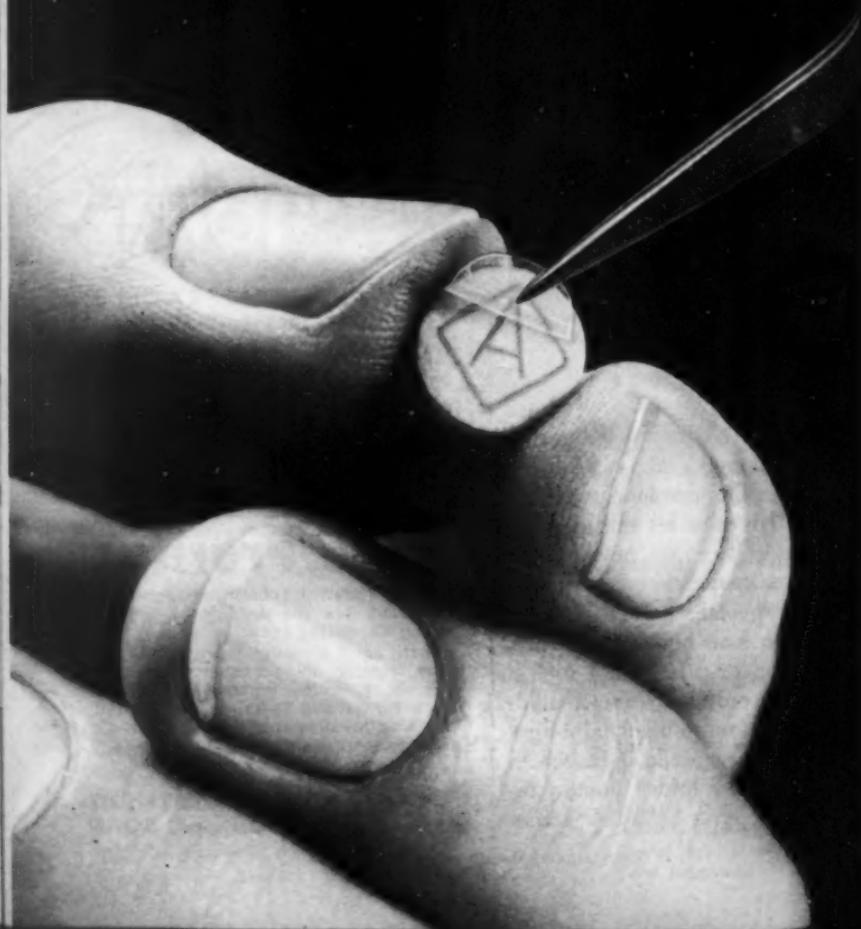
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ously gone out to a white person and liked him; I really hadn't known that I could.

Patients' Viewpoint

When I went on private service I was never restricted in contacts with patients. And there a woman patient very soon showed me that no involved reason lay behind my acceptance by white patients, that they could and did like and trust me. It was all as simple and human as that. This patient, who had a not unusual groundless suspicion, said to me, "Promise me that after I'm anesthetized, if my doctor doesn't do the operation himself, you'll do it."

Her words gave me more help than I could possibly have given her with my assurances that every private patient gets the skill and services of the doctor he has chosen. She so convinced me that white patients accepted me for myself that the one unpleasant incident that's ever come up couldn't shatter my faith. It happened when I told the wife of a patient that her husband needed special nursing care and asked if I could put through an order for three eight-hour-duty nurses.

She gave me a long look and said pointedly, "Yes, and see to it that all three are white."

I came here supposing that in a nonsegregated institution a Negro shouldn't expect help in solving his personal problems. I'd heard of some Northern colleges where a Negro could enroll, but couldn't live in the dormitories. But on my first day at

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Thoroughbreds are born, not made —



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Dosage: average adult,
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I JOINED THE HUMAN RACE

Memorial, Mr. Charles Hawkins, of the administrative staff, told me that the hospital owned a nearby block of buildings in which many of the staff lived. "We've three vacancies there now," he said. "Would you like me to show them to you?"

I knew the area wasn't colored and I thought Mr. Hawkins must be attempting something that wouldn't work. But as we looked at the apartments, something in his matter-of-fact manner began to chip at my skepticism, and when he showed me a place in a large, old, well-kept building, I at once thought of Clara and the youngsters in those six big rooms, where there was plenty of light, a nice bathroom and a good kitchen, and I took the leap and rented it. The rent came to sixty-five dollars a month.

One month later Clara came on from Nashville and brought the children. Although we were tautly tuned for it, we never felt any peculiar attitude toward us on the part of neighbors or in the area's shops.

Blood Money

The day after I took the apartment, Dr. Henry T. Randall, the present director of Memorial's surgical services, learned that I'd had experience measuring patients' blood volumes and gave me a job in the blood-volume laboratory he was just establishing. For this work I received \$150 a month and, with my resident's pay, we were able to get by financially. But just to get by. Clara and I never bought meat for our-

eliminate fatigue, headache, gas discomfort, "toxic" feeling due to **constipation**



"Doctor, I feel so much better," is the usual reaction of constipated patients as Occy-Crystine rapidly, gently, thoroughly clears the colon of constipation waste.

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selves, and sometimes we couldn't afford as much milk as the children should have had.

At the beginning of my second year my resident's pay became \$200 a month. I now have, in addition, a \$100-a-month fellowship from National Medical Fellowships, Inc., the country's only group concerned with aiding Negroes to secure medical training on all levels and with working to lower the barriers against my race in hospitals and medical schools. The fellowship income is a lifesaver to me, because with my increased hospital responsibilities I couldn't have continued the blood volume work, for which I had to be on call day and night. And this year, with both our children old enough to be

in nursery school, Clara has a secretarial job at the hospital. Between us we have an income large enough for comfort, even though we cannot be extravagant.

He Tensed Up

When I first came to the hospital, I was so concerned with doing well enough to prove to members of the attending staff that I merited being here that I was constantly in an agony of anxious tension when I worked with them. When I'd maintained this keyed-up pitch for two months, Doctor Randall called me into his office and said, "You're not here on trial. Nobody's watching for an excuse to get rid of you. But some of the attendings feel that you're un-

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an improved anticholinergic with
a mild sedative calms the
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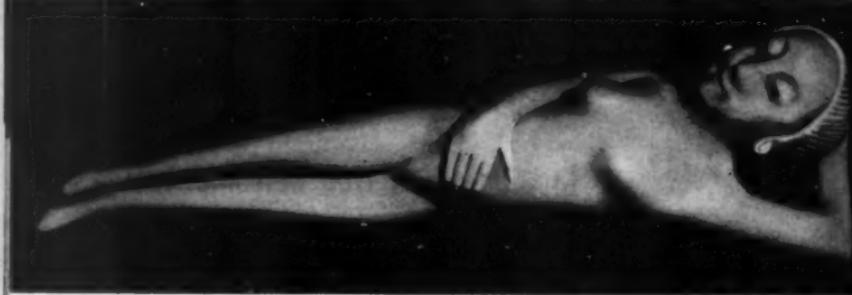
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'Elorine Sulfate' (Tricyclamol Sulfate, Lilly).....	25 mg.
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der a strain. I want to tell you that you're doing all right. Now, just relax and take us as we take you, won't you?"

His open handling of my mistakes attitude let me see that I'd taken for granted a lack of fairness in others. Eventually I might have floundered through unaided to this realization, but Doctor Randall brought it to me quickly and clearly and hearteningly. From then on, instead of mistrusting white people's good will until I have concrete evidence of it, I assume it until I have proof of bad will.

Best Friend Tells Him

One of the hardest shifts I had to make was from politeness to friendliness with the hospital's residents—the group in which any young house doctor should form friendships. Tim Renaud helped me here. He wouldn't accept mere politeness and refused to be subtle when he thought I needed to be jarred loose from lingering inhibitions.

He cracked down on me for my squeamishness at answering residents' questions about my experiences as a Negro. "Look, it's just as if you came from a foreign country we knew nothing about. If you met some doctor from Tibet or Timbuktu or Azerbaijan you'd put the siphon on him. You'd pump him good, especially about medicine. Open up and tell these guys what they want to know. It's your chance to help along interracial understanding in your own small way." [MORE→]

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30 patients, severe allergic symptoms.

"It is our belief that this drug used in this form provides the best method available for antihistamine medication."

—ROGERS, H.L.: Ann. Allergy 12:266 (May-June) 1954.

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357 patients, allergic disorders.

"66% of the group obtained excellent symptomatic relief; 16% obtained good relief; 11%, fair relief; 7% obtained no relief."

"[Teldrin' Spansule] capsules, aside from their long-acting property and low incidence of side effects, provide an obvious advantage of patient acceptance . . . they were heartily endorsed by nearly all patients."

—GREEN, M.A.: Ann. Allergy 12:273 (May-June) 1954.

"MOST USEFUL."

128 patients, hay fever.

"From these results, it is believed that the [Teldrin' Spansule] capsule is the most useful antihistaminic preparation currently available as adjuvant therapy in treating hay fever."

around-the-clock protection —MULLIGAN, R.M.: J. Allergy 25:358 (July) 1954.

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To give the physician a wider range of attack on
pain, a new analgesic has been combined with the “intermediate”
sedative, Butisol, and the widely prescribed sympathomimetic,
Syndrox, in—

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1. Hammes, E. M.: Pain Relieving Drugs, *The Journal Lancet*, 72:67 (Feb.) 1952.
2. Rehfuss, M. E.; Albrecht, F. K. and Price, A. H.: *Practical Therapeutics*, Baltimore, Williams & Wilkins Company, 1948, p. 128.

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Current reports^{1,2} describe the increasing incidence of resistance among many pathogenic strains of microorganisms to some of the antibiotics commonly in use. Because this phenomenon is often less marked following administration of CHLOROMYCETIN (chloramphenicol, Parke-Davis), this notably effective, broad spectrum antibiotic is frequently effective where other antibiotics fail.

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References

- (1) Kirby, W. M. M.; Waddington, W. S., & Doornink, C. M.: *Antibiotics Annual, 1953-1954*, New York, Medical Encyclopedia, Inc., 1953, p. 285. (2) Finland, M., & Haight, T. H.: *Arch. Int. Med.* 91: 143, 1953.

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DETROIT 32, MICHIGAN

I JOINED THE HUMAN RACE

Tim has become so interested in the race problem that he clips and makes me read everything he comes across about it and calls himself "The one-man clipping service." He's as close a friend as I've ever had. I owe it to Tim Renaud that today, when I think my racial background in any way responsible for my slant on some subject, I find it perfectly natural to join a discussion with, "Maybe my being a Negro has a good deal to do with what I think about this, but —"

How Children React

Little Clara entered Memorial's nursery school the fall after we came to New York, and Tony started going there as soon as he met the two-

and-one-half-year age requirement. Clara and I had some misgivings, because we knew that if Negroes were ever disparaged in the homes of our children's white playmates, this attitude would now be disclosed in cruelly revealing children's taunts and observations. We were sure our children would come home with endless questions about the difference between their looks and those of the white children. We know these will still come, and we hope we meet them as well as our white friends must be meeting them. We know how well they're doing, because so far there's been no word or incident to undermine the Perry children's happiness and self-assurance. To me, probably the one most

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important personal freedom of my present situation is that I feel no necessity for teaching my children protective servile politeness for their dealings with white people.

At Memorial, for inexpensive fun, about every six weeks we shove back the tables and chairs in the cafeteria and have a little house-staff dance. Clara was resourceful at finding plausible excuses for not going to these parties. When she tried to side-step the fourth consecutive one, I protested.

Change Partners

She admitted the truth. "I've never in my life danced with white boys. How do I know how I'd feel doing that? And how do I know that they'd dance with me at all? And if they did, wouldn't they just be doing it because they felt sorry for me, because they thought it was their duty?"

I induced her to sample one party. Clara's a good dancer and she had a whirl of a time. Now she's the one of us who clears away anything that might make us miss a hospital party.

The nursery school is co-operative and parents contribute time and work to it. Clara's experience in the treasurer's office at Hubbard makes it logical that she serve as the school's treasurer. This has given her increased acquaintance with the mothers of the other children, and she has good and fine friends among them.

The South, like every other sec-

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EPOLEM

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tion of America and all foreign countries, comes to Memorial. Contact with Southerners here has made alterations in my conclusions about and feelings toward the South. There was stunned disbelief on the face of the Atlanta doctor when we lined up to take our places for the operation on his sister and he saw that I was first assistant to the noted man who was to perform the surgery. I couldn't let his astonishment rattle me, but I wondered fleetingly about the close postoperative care that I, as the service's resident, would have to give the patient. Would this be the exception—the case for which my chief would feel forced to request the services of some other resident? No, it wasn't. The Atlanta

doctor and his sister accepted me smoothly; we had quite the typical relationship that should prevail among patient, nearest relative and the house-staff man on a case.

"Aren't you from the South?" a Mobile man asked me when I was changing a dressing, his second post-op day.

When I said I was, he took the old-home-week attitude and observed commiseratingly, "And up here you have to eat this damned Yankee grub day in and day out. Don't see how you stand it." Throughout his hospital stay he made us two Southerners together, temporarily enduring alien customs and ways.

Daily I sat in conference with a

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1 1/2-grain and 3-grain tablets

AVERAGE DOSE:

1 1/2 to 6 grains three or four times a day, before meals and at bedtime



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doctor from Lake Charles who came to observe work at Memorial. We talked a good deal, even discussing hometown people we both knew.

Different Down South

How would any of these people treat me if I were to meet them in Atlanta or Mobile or Lake Charles? The way a Southern white person treats any Negro, of course. I don't fool myself on that score. They'd not shake hands with me; they'd call me by my first name, but expect me to use a title in addressing them; in every way their behavior would imply that my color made me inferior. But from seeing them up here, I now think their home-ground attitude toward the Negro is a hollow thing

based on no intellectual conviction. Only the very aged and the very ignorant, I suppose, actually believe that color, *per se*, makes an individual inferior. The middle-aged, better-educated Southerners—and it's mostly representatives of this group that I've met up here—are carrying on something at home because it's traditionally expected of them.

What, then, can they pass along to their children and grandchildren? Just as an irreligious parent cannot instill religion in his child, no matter how great the demonstration of the forms of faith, so a parent who does not actually feel race hatred cannot instill it in his child. I see that segregation and discrimination will go on for some time, but in an increasing-

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ly halfhearted spirit. Finally, I'm sure, the maintenance of separate schools, hospitals, all the trappings of segregation, will be discarded as a useless burden from which the South will eventually disencumber itself.

Now that I have this viewpoint of the Southern attitude, I don't feel hostile toward the South and I have more pity than resentment for the people who string along with its outmoded code. Many young white Southerners realize that the South's advancement depends upon better race relations and are actively working to promote them. A strange new regional sense is beginning to enter my feelings. At present it is no more than a certain willing consciousness

of connection. What it will eventually become, I don't at all know. But already it has worked a minor miracle: I could live and work in the South. This is the one most startling result of my reversal in attitude.

Still a Negro

My adjustment, complete as it has been, hasn't made me forget that I'm a Negro. I could enter the human race only if I could take my color with me. I still have a few withholding minutes at the start of every new encounter with a white Southerner. Perhaps I always shall have. Three decades of wariness and carefulness may have made this pattern irreversible.

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HILSINGER, R. LARYNGOSCOPE 61:296, 1951.	25	20
WITTIG, F. ANN. ALLERGY 15:628, 1953.	35	32
VON WITTELEN, H. J. WISCONSIN M.A. 45:485, 1952.	28	26
BANKOFF, R., AND KISHMAN, S. CLIN. MED. 10:264, 1953.	26	24

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low workers, my awareness of my color may often stand me in good stead. When an exasperating situation arises with a patient, I don't allow myself to be sharp or even sternly firm, as every doctor is tempted to do; I excuse myself and leave the room for a few minutes. Last week, instead of saying to a garrulous woman who gave me quantities of irrelevant conversation, but no direct answers to my questions, "I don't give a darn what your sister-in-law said to you last Monday. What interests me are your symptoms," I left the examining room for a while. When I returned, she was able to be specific about what I had to know. And when I have differences of opinion or conflicting ideas with any of the people with whom I work, so that a little bad feeling and friction get underway, I nip it right then and set everything right immediately.

Right along, the armed services have deferred me to complete my training. As soon as I'm through, I want to do my hitch, whether or not doctors are then being drafted. This, too, is part of my reversal in attitude. Previously I never felt under any debt to my country. Now I think I owe it a great deal. Whatever may be the unsolved social problems of the United States, it's still the best place for white people and for black people.

And my permanent setup after the service? In any state which does not have legalized segregation I

think I could engage in a nonsegregated practice. There might be difficulties—but there shouldn't be too many. Since the war, cancer surgery has made remarkable strides at Memorial and there is no oversupply of Memorial-trained men. I believe my training here could outweigh the reluctance a Northern white hospital might have toward the appointment of a Negro to its attending staff. And I'm greatly attracted by the ideal of putting anything I can do at the disposal of anybody who asks for it.

Go Back South?

But the picture has its other side. Segregated Negroes are not segregated from cancer. Perhaps I should go back South, where I could work only among my own people. Clara and I both feel that we are sufficiently free from bitterness to return to segregation. But could our children adapt to it as easily as we have adapted to freedom? From nursery school little Clara often traipses off happily with other children to their home to eat lunch, nap and play with them. In the South we'd soon have to teach her that she couldn't play with white youngsters, that it's the sure road to trouble.

There's much to ponder in coming to a decision. I hope we reach the right one. And I hope, too, that in the future somehow we're able to help others get the same fair break we've had ourselves. It is the only door to freedom.

END



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1. Vainder, M.: Indus. M. & S., 22:183

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1. Magnuson, P.B., McElvenny, R.T., and Logan, C.E.: Jl. Michigan State Med. Soc., 46:71 (Jan.) 1947



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News

Form new institute for industrial medi-

cine • Blue Cross group rates made available to M.D.s • British doctor lauds American G.P.s • Too much medical advice in popular magazines? • 'Circuit riders' spread P.G. program

Warns Against Illegal Diathermy Equipment

If you're still operating an antiquated diathermy machine, you'd better get rid of it—fast. So say the editors of *Arizona Medicine*, pointing out that some 35 per cent of the diathermy machines now in use are illegal. Most of this equipment, the doctors explain, was acquired before 1947—the year the Federal Communications Commission "first assigned definite frequencies for diathermy operation."

The continued use of illegal machines may not only prove costly (the penalty is a fine of up to \$10,000, plus a two-year jail sentence) but dangerous as well. So powerful are the waves given off by the equipment, says *Arizona Medicine*, that an illegal signal could:

¶ "Throw a radio-controlled guided missile off its course; or even attract one . . . and bring you a Nike, for example, with all its destructive force."

¶ "Foul up instrument landings at

the airport, causing an airliner to crash."

¶ "Interfere with police and other emergency short-wave calls from miles around."

'Doctors Need Protection From A.M.A. Power'

That's the chief finding of a study by law students

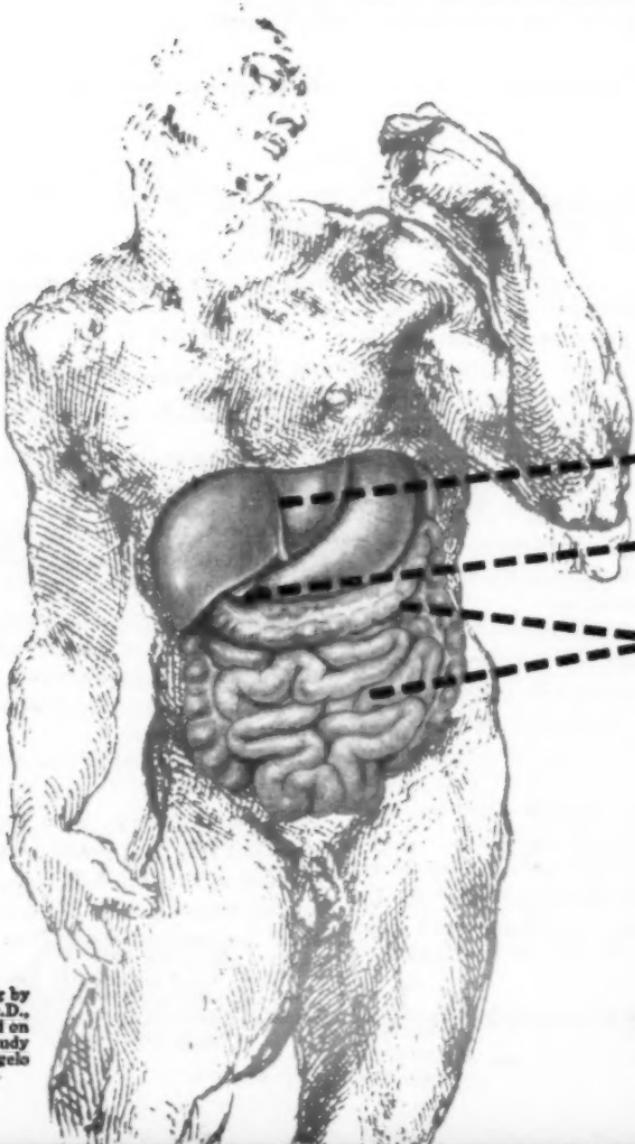
The A.M.A. not only yields excessive authority over medical practice in this country; all too often, it fails to use its power as an "instrument of progress." So report the student-editors of the *Yale Law Journal* after completing a two-year analysis of American medicine.

Principal authors of the report* are David R. Hyde and Payson Wolff, who received their law degrees last June. They base their conclusions mainly on A.M.A. records and on questionnaires filled out by state medical societies. They find

* "The American Medical Association: Power, Purpose, and Politics in Organized Medicine." *Yale Law Journal*, May, 1954.

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works throughout hepato-intestinal system

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NEWS



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much to praise—but they find more to criticize.

The student-lawyers readily concede "A.M.A. successes in raising the quality of medical education, practice and care." Their attack is concentrated on what they call the organization's "monopoly position as spokesman for the profession." The A.M.A., they argue, "has achieved such power" that the individual doctor needs to be protected from "unreasonable exercise of organized medicine's authority."

But the youthful critics think they know what steps should be taken to correct the situation. Among their recommendations:

¶ Less emphasis should be placed on medical society membership. Says the report: "Dissident physicians might better be able to resist A.M.A. views if, for example, government and specialty board appointments were not dependent upon membership." Another effective way to de-emphasize membership would be to "insure availability of hospital privileges to non-members."

¶ Legislatures should stop state medical societies from exercising "quasi-legal control over the formation of health insurance plans." As the budding lawyers see it, "Statutes requiring approval or participation by the medical society or a majority of doctors have [hindered] . . . the development of new methods for providing low-cost prepaid care."

¶ "Organized medicine should be divested of its control over the nation's supply of doctors." At present,

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NEWS

argue the Yale students, "high A.M.A. standards, combined with lack of funds, impose a practical limitation upon the number of M.D.s graduated each year." They maintain that "the doctor supply, so crucial to the nation's well-being, should not hinge upon the financial condition of medical schools. Federal aid to medical education would help divorce the size of classes from standards of quality."

As if anticipating doctors' objections, the Yale report concludes with this thought:

"In the past, the A.M.A. has condemned as unethical various medical practices which it now approves and advocates . . . New ideas which the Association has accepted have been forced upon it. By assuming leadership in experimentation with unproved systems of practice and payment, the A.M.A. could become an instrument of progress."

Industrial Physicians Look To New Institute

Industrial medicine got a boost recently with the establishment in New York City of a new organization called the Occupational Health Institute. Its function: to help industrial firms set up better health programs for their employees.

Sponsored jointly by management and medicine, the institute will conduct studies for industrial concerns all over the country. Through its thirty-two regional directors (all leaders in industrial medicine), it

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will seek to lift workers' health standards.

Comments Dr. Robert Collier Page, chairman of the organization's board: "Management is becoming increasingly aware that good health is good business. But there often is confusion as to how best to provide the right quantity and quality of medical service for employees. Thus the institute will fill a real need . . ."

'G.P.s Save You Money,' Says This G.P.

Don't go running to a specialist with every little ailment, Dr. Francis T. Hodges warns prospective patients in a recent issue of Collier's. A competent general practitioner,

he points out, can take care of ordinary medical needs at a considerable financial saving.

By way of illustration, the San Francisco G.P. offers the following example from his own practice:

"The other day a patient came to me with a case of acute sinusitus, a wart on his finger, and a hemorrhoid complaint. I gave him a prescription for his sinusitus, eliminated his wart with an electric needle, and took care of his hemmorrhoid discomfort with injections. My fee? Ten dollars.

"If the patient had gone to an ear, nose, and throat specialist for his sinusitus, a dermatologist for his wart, and a proctologist for his hemorrhoids, the total fee would



MORE JOBS FOR M.D.s in industry is one goal of a new institute headed by Dr. Robert C. Page.



LESS NEED FOR SPECIALISTS. Most ailments can be treated by G.P.s, says Dr. F. T. Hodges.

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2. Cronheim, G.; Brown, W.; Cawthorn, J.; Toekes, M. I., and Ungari, J.: Proc. Soc. Exper. Biol. & Med. 86:110 (May) 1954.

Rauwiloid is fractionated only from true, unadulterated *Rauwolfia serpentina*, Benth. It shows virtually no side actions, even fewer than other rauwolfia preparations, and there are no contraindications. It rarely needs upward dosage adjustment.

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have been a minimum of \$25 to \$30, and might have reached \$75—and the treatment would have been identical.

"This case is not isolated," Dr. Hodges maintains; "the average patient who comes to my office has several complaints." Of course, adds the doctor reassuringly, "if any of the three ailments I mentioned had been unusual, I naturally would have called in a specialist."

Doctors Get Group Rates Under Blue Cross

Beginning this fall, physicians who belong to the New York County medical society can get Blue Cross hospitalization coverage through their society. Main advantage of the new plan: It will enable doctors to take advantage of the lower group rates for themselves and their families. Manhattan M.D.s who had such coverage in the past paid the higher individual rates.

Raps Psychiatrists Who Charge Other M.D.s

"Some psychiatrists," reports the Norfolk (Mass.) Medical News, "tell a fellow physician before treating him or a member of his family that they expect to receive fees for such services." The News doesn't like it. Nor does it look approvingly on a move by the American Psychiatric Association to relax the rules of professional courtesy in favor of psychiatrists.

[MORE→]

"Psychiatrists have labored long and hard to be accepted as legitimate, honored, and necessary members of the medical profession," comments the News. "The results of their proposal for a change in the ethics of the medical profession might be more far-reaching than the psychiatrists themselves anticipate. More analysis (non-Freudian style) should be given by the psychiatrists to the solution of their problems, before recommending changes in the Code of Ethics which appear to foster monetary gain."

No Whistling, Please

"Doctors should watch out for likely girls on the street . . ."

This improper-sounding suggestion seemed perfectly proper to delegates of the American Osteopathic Association. Why? Because the speaker, William A. Jenkins, was offering his solution to a problem that plagues a good many professional men: the secretary shortage.

The best way to find "a good-looking, competent girl," he advised, was to spend part of your time as a sidewalk "talent scout."

Advise Closer Study of Patient's Personality

To help reduce patients' complaints against doctors, medical societies should devote more meetings to personality study—"if necessary, at

Millions prescribed yearly...

A hand holds a prescription that reads:
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MEDICAL ECONOMICS • OCTOBER 1954

the expense of scientific programs." That's the recommendation of Dr. Paul F. Whitaker of Kinston, N. C.

Speaking as a member of the North Carolina medical society's grievance committee, Dr. Whitaker reports that one of the commonest complaints to come before that group is "a feeling of insult to the dignity of mind or person." Patients who complain thus, he says, have the impression that in some way the physician has slighted them as human beings.

How can the practitioner help prevent such complaints? By learning more about the psychologic make-up of his patients, Dr. Whitaker suggests. He strongly urges medical societies to initiate study

programs that will acquaint members with "the social and psychologic factors of ill health and disease."

By applying the knowledge thus gained, says Dr. Whitaker, "we can . . . restore to the practice of medicine certain intangibles which the patient feels have been lost, which he resents losing, and which he complains about losing."

British M.D. Reports On American G.P.s

Says that general practice in this country is thriving

How does American general practice compare with its British counterpart? In the spring of 1952, Dr.

now 50%
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antipernicious anemia factor

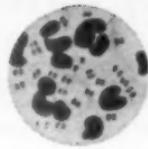
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1. Jawetz, E.: California Med. 79:99 (Aug.) 1953. 2. Cecil, R.L., and Loeb, R.F.: Textbook of Medicine, W. B. Saunders Co., Philadelphia, 1951, pp. 963-967. 3. Sophian, L.H., and others: The Sulfapyrimidines, Press of A. Colish, New York, 1952. 4. Berkowitz, D.: Antibiot. & Chemo. 3:618 (June) 1953.

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Charles M. Fleming, Principal Medical Officer for Scotland, under the National Health Service, came over here to find out. And just recently he published his findings in the British Medical Journal.

Dr. Fleming's fact-finding trip, which was sponsored by the Rockefeller Foundation, lasted three months. In that time, he traveled extensively in the North, South, and Middle West, observing "both urban and rural practice under widely varying conditions."

How did he react to what he saw? Dr. Fleming was obviously impressed by the healthy state of American general practice, by the quality of the work he saw done, and by the excellence of the facilities available

to G.P.s. Here's a sample of his comments on some of these subjects:

¶ *On accommodations and equipment:* "The American practitioner often has professional accommodation and equipment on a scale seldom seen in [Great Britain] . . . I never met any doctor who had less than three rooms and whose equipment was not well above the British average . . . Perhaps two of the best buildings I saw were in small rural practices in Mississippi . . . The first experience I had of a waiting room belonging to a New York group made me feel I was in the lounge of a luxury hotel."

¶ *On laboratory facilities:* "It is a common criticism of American medicine . . . that too many laboratory

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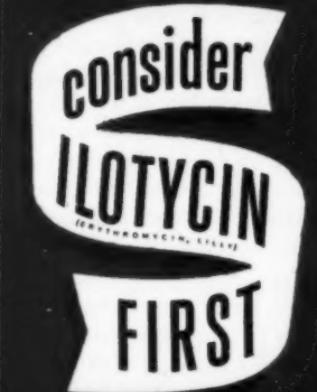
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tests are performed . . . My own experience was that the good general practitioners . . . did not abuse laboratory tests . . . General practitioners in Great Britain would do well to avail themselves of [such] useful corroborative diagnostic evidence."

¶ On hospital appointments for G.P.s: "Almost every doctor whom I met had some form of association with a hospital . . . A statement that in one large city only 56 per cent of the general practitioners had a recognized hospital affiliation . . . [was] quoted as disappointingly low from the American point of view. In Britain such proportions . . . would be regarded as startlingly high."

Dr. Fleming was also impressed by the scope of American general practice. He was surprised, for example, to find "occasional major surgery by general practitioners . . . done in places like New York and Baltimore, where expert surgical skill abounds." What's more, he adds, it's his opinion that the American G.P. does "a better job in many, but not all, ways" than is done by his British counterpart.

What flaws did Dr. Fleming discover in the American system of general practice? Says he: "It did seem to me . . . that more time might sometimes have been given to consideration of the patient as a person."

But he concludes his report with a full vote of confidence: "At the beginning of my visit, a knowledgeable adviser told me that . . . the general practitioner in America was

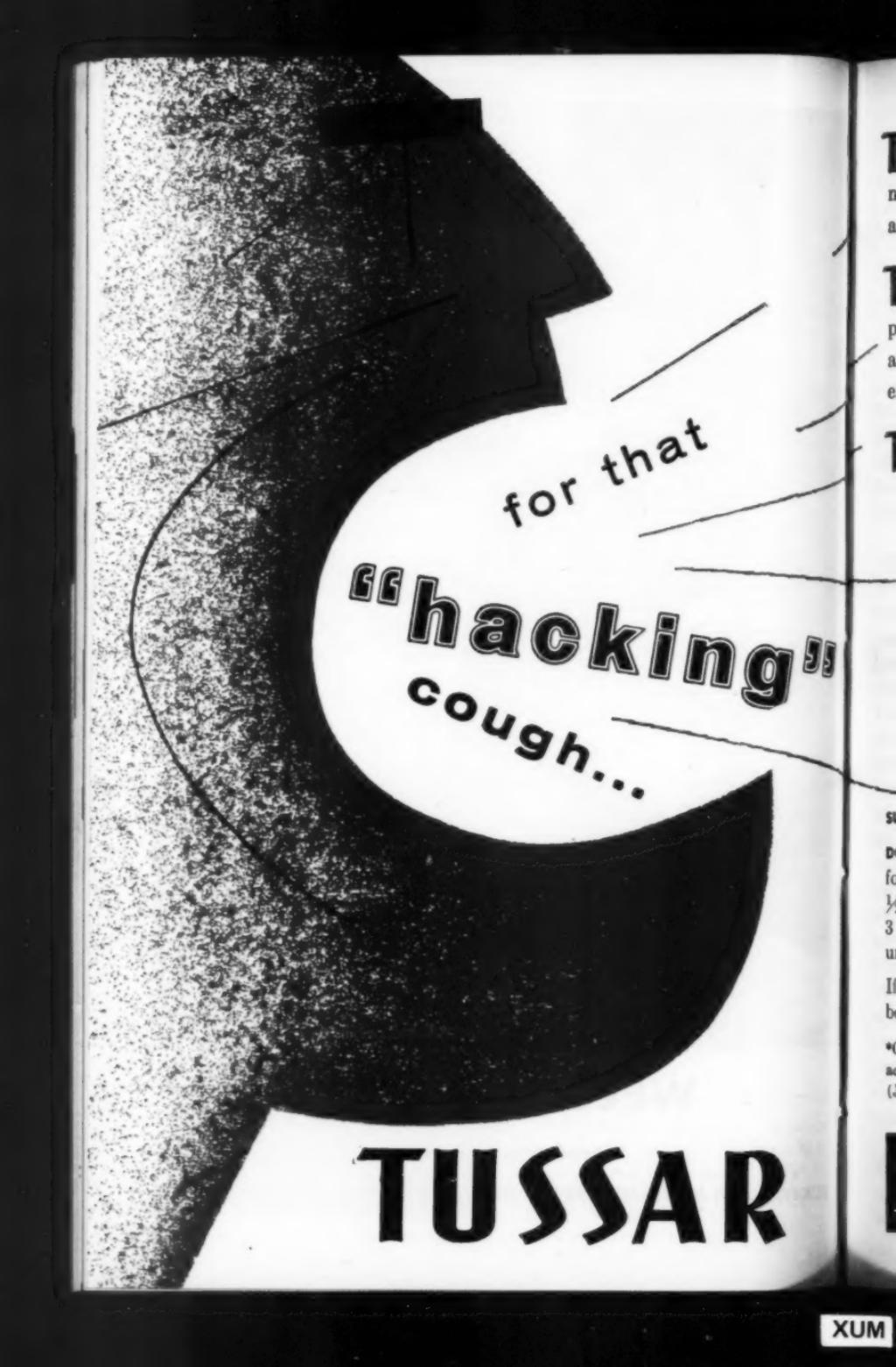


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a disappearing entity . . . I can answer emphatically that I saw no reason to fear for the future of general practice."

Sees Too Much Medical Advice in Magazines

"Today's magazines are full of . . . enough medical advice to confound the Brothers Mayo or the late Sir William Osler." That's the complaint of Scripps-Howard columnist Inez Robb, and she backs it up with considerable spirit:

"For some years now, most magazines have employed at least one house physician who fills each issue with dandy descriptions of causes, cures, symptoms, aches, pains and sympathetic cluckings. The bedside manner oozes through the slick pages so artfully that a magazine subscriber is hard put to determine whether he is a reader or a patient."

Miss Robb points out that some people, of course, lap up every bit of this gratuitous counsel. Says she: "I number among my friends a consecrated hypochondriac whose life has been positively radiant ever since magazines went in for medical malarkey . . . Whatever her favorite magazine comes down with, she is laid up with, too. At the moment she is suffering from galloping dandruff and eagerly looking forward to clip joints and fallen arches, announced for next month's issue."

But magazine medicine is not for Miss Robb. Neither is magazine psychiatry ("aimed at readers who are

NEWS

alive but not entirely reconciled to that fact"). What she wants, says Miss Robb, is a "return to the good old days when magazines left body and soul to the private ministrations, privately arrived at, of physician and prelate."

P.G. Program Works 'Like a Circus'

Circuit-riders are making the rounds again in Kansas—this time in the interests of post-graduate medical education. A program sponsored jointly by the University of Kansas School of Medicine and the state medical society sends teams of doctors, dietitians, and nurses into every corner of the state.

The M.D. circuit-riders, all members of the medical school staff, go out in pairs. Each twosome takes a one-week swing through the state. The school furnishes them with a chauffeur-driven car. Doctor-members of the team are paid \$50 a day plus expenses.

"We work just like a circus," explains Dr. E. Grey Dimond, professor of medicine at the medical school. "Two weeks ahead of time, a man goes out to sign up the doctors and tell them the circus is coming." Each doctor who signs up pays \$25 for six sessions.

The program has proved so popular that physicians from adjoining Missouri have asked to be included. So the Kansas circuit-riders now take in the Springfield and Joplin areas.

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Subject Index to

Medical Economics

April to September, 1954

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AMERICAN MEDICAL ASSOCIATION

- A.M.A. Relents.* April 4
'Curb the A.M.A. by Law! April 219
Doctor-Veteran Peace? April 9
Acceptance of D.O.s. May 4
Action Aplenty. May 56
A.M.A. Membership. May 45
New Pamphlet Questions V.A. Statistics. May 258
Newspaper Blast Draws Fast A.M.A. Reply. May 282
Remove the Stigma? May 97
A.M.A. Membership. June 82
Change of Heart. July 97
Tomorrow's Doctor: What Are His Goals? July 124
Where They Come From. July 21
Sum-Up of A.M.A. Actions. Aug. 7

ASSISTANTS

- Breaking In an Aide.* May 153
Aides Get Special Blue Shield Coverage. June 272
Lab Workers Sought. June 245
Training the M.D. Aug. 58

BIOGRAPHY

- Houston, Charles, High Adventurer.* April 133
Johnstone, R. T., Industrial Medicine's 'Private Eye.' May 124

- Mattison, P. A., *He Built It Himself.* May 105
Larson, Charles P., *Crime Doctor.* June 103
Newcomb, Kate Felham, *Physicians Conspire to Put Colleague on TV.* June 258
Archer, Harry M., *Doctor's Death Saddens Fire Fighters.* July 234
Reiling, Walter A., *Silver-Lining Specialist.* July 104
Adams, Fae, *Bars on Her Shoulders.* Aug. 154
Palmer, Benjamin J., *A Visit With B. J. Palmer.* Aug. 132
Kerr, Robert H., *Doctor-Ruler of the Khyber Pass.* Sept. 157

BLOOD BANKS

- Blood Banks.* April 50
Red Cross Blood. June 45
Blood Feud. July 9
How to Build a Blood Bank. July 136

CHARITY CONTRIBUTIONS

- How Doctors Are Tricked by Charity Swindlers.* Sept. 231

CHIROPRACTORS

- Chiropractic's New Twist: An Invasion of Industry.* May 114
Chiropractors Rebuffed. June 7
They're Clever With Words. June 21
A Visit With B. J. Palmer. Aug. 132



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1. Russek, H. I.; Urbach, K. F.; Doerner, A., and Zohman, B. L.: J.A.M.A. 153:207 (Sept. 19) 1953. 2. Winsor, T., and Humphreys, P.: Angiology 3:1 (Feb.) 1952.
3. Plotz, M.: New York State J. Med. 52:2012 (Aug. 15) 1952.

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SUBJECT INDEX TO MEDICAL ECONOMICS

Spine Men Conduct Their Own Polio Drive. Aug. 212

COLLECTIONS

Collection Agencies. April 77
Doctors Collect Less. April 82
Why Not Use Charge Slips? April 148
Collecting Bills. June 52
Installment-Plan Care. July 8
Medical Society Sets Collection Rules. July 218
New Light on Itemizing. Aug. 117
Unpaid Accounts. Aug. 77

DOCTOR DRAFT

Doctor Draft Unfair? April 45
Matching Plan for G.I.s. April 7
Patriotism Among M.D.s. July 54

DRUGGISTS

Druggists Devise New Ways to Woo M.D.s. April 270
Are Your Patients Getting Counterfeit Drugs? Sept. 113
M.D.s Advised to Heed Druggists' Calls. Sept. 276
Some Druggists Seek More Leeway in Dispensing. Sept. 302

EDUCATION

Begin Drive for Modern Medical Museum. April 284
Urge Wider Use of TV for P.G. Classes. April 235
Cost of Medical School Training Set at \$9,- 200. May 240
New Medical Students Get Bedside Training. May 253
American in Vienna. June 144
Devise New Home Study Plan for Physicians. June 250
Medical Students Given Courtroom Training. June 256
TV Proved a Valuable Teaching Aid. June 263
Where Are the Models? June 28
Americans Favor Swiss Medical Schools. July 210
Color TV Aids Teaching. July 5
Initiate 'A.M.A. Day.' July 230
Students Look Ahead. July 21
Surgeon's Scholarships Aid Needy Students. July 224
Tomorrow's Doctor: What Are His Goals? July 124
Urge Cut in Training Period for M.D.s. July 243
Is the Family Doctor Obsolete? Aug. 161

Grateful M.D. Sets Up Medical Scholarship. Sept. 261
No Dirty Books? Sept. 290
Research Grants. Sept. 78

EQUIPMENT

Easy Upkeep Was the Aim in This Office. April 144
Your Business Stationery. April 109
Big Cars for M.D.s. May 60
Advice on Printing. June 58
Air-Conditioner-Switch. June 244
Automatic Typing—Boon for Busy Offices. June 179
Boom Year Seen for Car Air Conditioners. June 250
Silent Dictation. June 256
Business Stationery. July 50
Clears the Air. Sept. 296
Reproducing Forms. Sept. 75
This Doctor Really Built His Dream Office. Sept. 134

ETHICS

Ethics Charges. April 45
Open to Attack. April 28
They Prevent Grievances. April 99
Sets Up Ethics Code for M.D.s Who Broadcast. May 268
Panel-Plan Fight. June 8
A.C.S. Closes In on Fee Splitters. Sept. 161
Communists Rewrite Medical Ethics. Sept. 291

EXPENSES

M.D.s Pay \$34 Million Yearly for Dressings. June 239
Office Expenses. Aug. 77

FEES

Fee Splitting. June 50
Psychiatrists' Fees. June 48
Witness Fees. June 78
Attacks Plan to Set Up Uniform Medical Fees. July 222
Fees for Clergymen. July 77
Fee Grab by Hospitals. July 99
House-Call Fees Up. July 6
'Usual Fee' Plan Put to Test. July 131
An A.C.S. Victory? Aug. 7
Fee Frauds Exposed. Aug. 4
Fixed Fees Urged. Aug. 6
How Much Do Doctors Charge? Aug. 100
Labor Demands Full Coverage—at Doctors' Expense. Aug. 124
What Do Doctors Think About Blue Shield? Aug. 147

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1947 CONCEPT PROVEN	Hesperidin and ascorbic acid increase capillary resistance by inhibition of hyaluronidase action. Combination of bioflavonoid and ascorbic acid markedly potentiates this inhibitory action. ³
1948 DIABETIC RETINOPATHY	Improvement—cessation of further bleeding; absorption of exudate and hemorrhages. ⁴
1948 PSORIASIS	Hesperidin with ascorbic acid more effective than latter drug alone to decrease capillary permeability and increase capillary resistance. ⁵
1948 RHEUMATOID ARTHRITIS	Hesperidin essential for absorption and retention of vitamin C—action synergistic to maintain normal capillary resistance which may enhance efficacy of other therapeutic measures. ⁶
1949 DIABETES HYPERTENSION	Capillary fragility in all patients with plasma vitamin C levels above adequate. Despite inadequate dosage, capillary fragility decreased, including one hypertensive with azotemia. ⁷
1949 DIABETES ARTHRITIS HYPERTENSION	Within 9 weeks all diabetic patients had normal petechial index. Four of 6 arthritic patients showed objective improvement. ⁸ Of 50 hypertensive patients, 40 had a normal petechial index within 8 weeks, remaining normal on maintenance dose over a period of 10 months. ⁹
1949 RHEUMATOID ARTHRITIS	Prognosis good with correction of capillary fragility by use of Hesperidin-C in adequate doses and other physical, nutritional and occupational therapy. ⁹
1950 HYPERTENSION ARTERIO-SCLEROSIS ARTHRITIS	ANEMIA Vitamin C important to maintain integrity of capillary GINGIVITIS intercellular substances; hesperidin essential as catalyst OBESITY to combine vitamin C with protein fraction to form this substance. ¹⁰
1951 PERMEABILITY FACTOR	Inhibition of hyaluronidase by the bioflavonoid with resulting decreased permeability of the cell. ¹¹
1953 EDEMA	Hesperidin-C reduced edema and improved nutrition and function in 22 of 24 (91%) of patients with inoperable or recurrent carcinoma of intra-abdominal origin. ¹²
1953 ABORTION	More than 80% of OB patients with history of habitual abortion have high petechial indices. ¹³
1954 SYNERGISM	Hesperidin and ascorbic acid. Naturally occurring synergists—bioflavonoids, hesperidin, ascorbic acid. ¹⁴
1954 ABORTION	In 100 OB cases prone to habitual abortion, "before" and "after" treatment results with Hesperidin-C follow: Spontaneous abortions fell from 95.2% to 11.9%; premature and full-term deliveries rose from 3.6% to 87.3%; therapeutic abortion fell from 1.1% to 0.3%. ¹⁵
1954 ABORTION	In pregnancies in patients with repeated late abortions, Hesperidin-C permitted 50% to go to full term with normal, living babies. Dosage was only 400 to 600 mg. each of hesperidin and ascorbic acid daily. ¹⁶

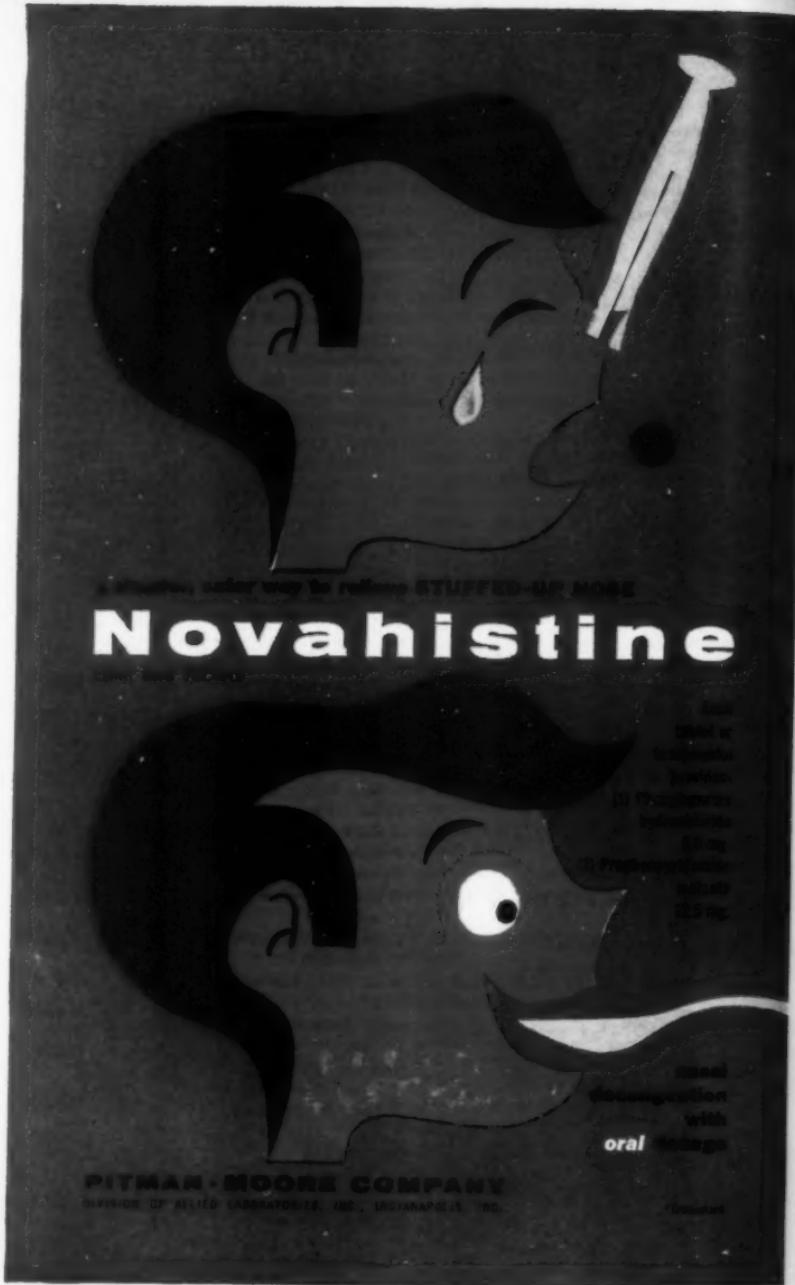


References 1-16: Annotated bibliography on ORIGINAL RESEARCH on hesperidin and ascorbic acid in combination is available on request.

THE NATIONAL DRUG COMPANY Philadelphia 44

SUBJECT INDEX TO MEDICAL ECONOMICS

- A.C.S. Closes In on Fee Splitters. Sept. 161
Copy the Panel Plans in Discussing Fees?
Sept. 280
Cutting OB Fees. Sept. 75
How They're Fighting the Kaiser Plan. Sept.
126
Psychiatric Costs. Sept. 45
Shopping-Center Practice Is Here to Stay.
Sept. 100
- FOREIGN DOCTORS**
British G.P.s Urged to Set Up Groups. April
276
Friendly Invasion. April 233
Soviet Doctors Cool to Rural Practice. April
284
Britons in the Mold. May 28
Foreign Doctors. May 46
Screen Alien M.D.s? June 7
Society Admits Aliens. June 240
Communists Rewrite Medical Ethics. Sept.
291
Fewer Solos. Sept. 24
Tells of Heavy Patient Load of Soviet M.D.s.
Sept. 268
- GENERAL PRACTICE**
Fighting Words. May 6
G.P.s-Minus and Plus. May 98
Claims G.P.s Don't Try to Prevent Disease.
July 215
Tomorrow's Doctor: What Are His Goals?
July 124
Is the Family Doctor Obsolete? Aug. 161
G.P.s Recoup Numerical Losses. Sept. 5
- GRIEVANCE COMMITTEES**
They Prevent Grievances. April 99
Tips for Grievance Boards. May 131
- GROUP PRACTICE**
British G.P.s Urged to Set Up Groups. April
276
Tips on Group Practice. May 46
This Group Made Good! June 99
Group Practice. July 46
M.D.s in Groups. July 6
Tomorrow's Doctor: What Are His Goals?
July 124
If You Need an Associate. Aug. 112
Fewer Solos. Sept. 24
- HEALTH INSURANCE**
Could Health Insurance Survive a Depression?
April 231
'Curb the A.M.A. by Law!' April 219
How Reinsurance Would Work. April 104
Kaiser's Heel. April 8
- More on Radiology. April 54
Reinsurance—a Good Thing? April 97
Union Blasts Private Health Insurance. April
257
Boost for Prepaid Care. May 8
New Closed-Panel Plan Nearly Ready to Go.
May 233
New Forms to Aid M.D.s. May 5
Reinsurance Paradox? May 6
Setting Them Straight. May 25
What We've Learned About Prepayment. May
146
Aides Get Special Blue Shield Coverage. June
272
Panel-Plan Fight. June 8
Proposes Sales Tax to Pay Health Costs. June
249
Too Full Coverage. June 45
Views on Reinsurance. June 77
And Now: Insured Teeth. July 6
Attacks Plan to Set Up Uniform Medical Fees.
July 222
Blue Shield Blues. July 7
Blue Shield Plan Ups Income Ceiling. July
209
Blue Shield's Role in the Future of Medicine.
July 161
Fee Grab by Hospitals. July 99
Insurance Ad Ethics. July 4
Tomorrow's Doctor: What Are His Goals?
July 124
'Usual Fee' Plan Put to Test. July 131
Why Reinsurance Can't Work. July 147
Compulsory Health Plan Deemed a Failure.
Aug. 210
Labor Demands Full Coverage—at Doctors'
Expense. Aug. 124
Prepay Plan in Crisis. Aug. 5
Rx for Panel Medicine. Aug. 97
What Do Doctors Think About Blue Shield?
Aug. 147
Asks U.S.-Backed Loans for Closed Panels.
Sept. 259
Blue Shield Leaders. Sept. 4
H.I.P. Ads. Sept. 50
How They're Fighting the Kaiser Plan. Sept.
126
Just One More Day. Sept. 21
Political Preview. Sept. 7
Prepay Abuses. Sept. 52
- HOSPITALS**
Charges Hit Hospitals. April 4
Crashing Bore. April 26
Deplores Treatment of Children in Hospital.
April 279



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SUBJECT INDEX TO MEDICAL ECONOMICS

Do the Private Hospitals Need to Clean House? April 139

Patients Flock to Help D.O. Hospital Drive. April 225

Psychiatrists Analyze Mental Hospitals. April 272

What 'Interne Matching' Is—and What It Isn't. April 122

Fighting Words. May 6

G.P.s—Minus and Plus. May 98

Hospital Privileges. May 50

Hospitals Too Lax? May 7

Says Hospital Planning Is Still Inadequate. May 273

Says Tissue Committees Are of Little Value. May 244

Freedom of Expression. June 58

Hits Salaried Men. June 4

Hospital Offers M.D.s Formula for 'Gifts.' June 239

They Keep Score on Staff Physicians. June 109

Too Easy to Oust. June 97

Fee Grab by Hospitals. July 99

Hospital Costs Rise. July 210

Enters Battle Over Salaried M.D.s Aug. 195

Fees Frauds Exposed. Aug. 4

Is the Family Doctor Obsolete? Aug. 161

Hospital Births Boom. Sept. 295

HUMOROUS COMMENTARY

Doctor at Sea. April 169

Notations From a Doctor's Notebook. April 193, May 193, June 160, Aug. 156, Sept. 243

The Pill That Parallels Your Problems. May 187

'Vacation With Pay.' May 144

The Gentle Art of Hatching a Malpractice Suit. June 131

Under the Weather. July 134

The General Specialist. Aug. 110

Schmidt's Law. Sept. 132

INCOME

Safeguarding Your Practice When You Take Time Off. April 126

Health Officers' Pay. May 5

If You Need an Associate. Aug. 112

Dollar Value Plummets. Sept. 7

Looking Toward Liquidation. Sept. 97

Shopping-Center Practice Is Here to Stay Sept. 100

INDIGENT CARE

An Indigent-Care Program That Really Works. May 101

M.D.s Deplore New Plan for Indigent Care. May 236

INDUSTRIAL MEDICINE

Early Recognition Seen for Industrial M.D.s.

April 281

Industrial Doctor: the Man in the Middle. April 151

Chiropractic's New Twist: an Invasion of Industry. May 114

Community Backs Health Check-Ups for Workers. May 284

Industrial Medicine's 'Private Eye.' May 124

Getting a Start in Industrial Practice. June 124

Industrial Practice. June 54

Industrial Practice. Aug. 52

Labor Demands Full Coverage—at Doctors' Expense. Aug. 124

INSURANCE

Are You Getting Top Mileage From Your Car Insurance? May 118

Fire Insurance. May 80

Misadventures of an Insurance Doctor. May 106, June 135, July 149

Offer Package Insurance. May 9

Polio Insurance. May 60

Malpractice Insurance. June 58

Are There Gaps in Your Insurance Coverage? July 110

Disability Insurance. July 4

Auto Insurance. Aug. 78

Malpractice Rates Rise. Sept. 4

INVESTMENTS

Short-Term Trusts Offer Income Tax Savings. May 159

What About Those Monthly Investment Plans? May 161

Interest Payments. July 80

LAW

Take Another Look: It Could Be a Contract. April 160

Are State Laws Against Birth Control Legal? May 233

Dead Men's Tales. May 284

Lawyer Gives Tips to M.D.-Witnesses. May 262

Medical Students Given Courtroom Training. June 256

Witness Fees. June 78

Oral Prescriptions. July 4

M.D. Faces Long Fight for Patent Rights. Aug. 202

Rules for Rx's. Aug. 80

When You Can Drop a Case. Sept. 203

LEGISLATION

How Reinsurance Would Work. April 104

Announcing

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SUBJECT INDEX TO MEDICAL ECONOMICS

Reinsurance—a Good Thing? April 97

Views on Reinsurance. June 77

Change of Heart. July 97

Why Reinsurance Can't Work. July 147

Illinois Medical Leader Raps Administration.

Aug. 205

Asks U.S.-Backed Loans for Closed Panels.

Sept. 259

Political Preview. Sept. 7

LICENSURE

License by Endorsement. June 85

Single-License Plan. Aug. 4

LOCATION AND DISTRIBUTION

'Good Spread of M.D.s.' April 7

More U.S. Dentists. April 231

'335,000 Nurses Aren't Nearly Enough.' April

264

Doctor Distribution in the U.S. May 8

Tomorrow's Doctor: What Are His Goals?
July 124

Rural Physicians Reach Wide Areas by Plane.
Sept. 292

Shopping-Center Practice Is Here to Stay.
Sept. 100

MALPRACTICE

Malpractice Insurance. June 58

Malpractice Rates Rise. Sept. 4

MEDICAL COSTS

Setting Them Straight. May 25

U.S. Health Costs Set at \$72 per Person. May
267

MEDICAL SCHOOLS

'Public Health Schools Need U.S. Aid.' April
235

Cost of Medical School Training Set at \$9,-
200. May 240

American in Vienna. June 144

Where Are the Models? June 28

D.O.s Desire Peace. Sept. 5

Urge Medical Schools to 'Bill' Graduates.
Sept. 284

MEDICAL SOCIETIES

Emergency Calls. April 52

Kaiser's Heel. April 8

They Prevent Grievances. April 99

Two Cures for Plethora of Medical Meetings.
April 227

An Indigent-Care Program That Really Works.
May 101

Clock-Minded Doctors Are Commended. May
276

M.D.s Deplore New Plan for Indigent Care.

May 236

Sets Up Ethics Code for M.D.s Who Broadcast. May 268

The Doctor's Health. May 5

Tips for Grievance Boards. May 131

A Present for Prexy. June 122

A.M.A. Membership. June 82

Panel-Plan Fight. June 8

Physicians Step Up Safety Campaigns. June
255

Should Doctors Be Paid for Committee Work?
June 269

Society Admits Aliens. June 240

Change of Heart. July 97

How to Build a Blood Bank. July 136

Medical Society Head Goes Out Swinging.
July 225

Medical Society Sets Collection Rules. July
218

Tomorrow's Doctor: What Are His Goals?
July 124

'Usual Fee' Plan Put to Test. July 131

An A.C.S. Victory? Aug. 7

Enters Battle Over Salaried M.D.s Aug. 195
Labor Demands Full Coverage—at Doctors'
Expense. Aug. 125

Single-License Plan. Aug. 4

Veterans Society Grows. Aug. 210

A.C.S. Closes In on Fee Splitters. Sept. 161

County Rule Upheld. Sept. 54

Helpful Societies. Sept. 283

How They're Fighting the Kaiser Plan. Sept.
126

Planners of Medical TV Programs Get Low-
down. Sept. 264

Rx for Parking Woes. Sept. 9

Separatist Movement. Sept. 261

MILITARY MEDICINE

Dependent Care. April 52

Doctors Perform 'Operation Streamlining.'
April 5

Why Do Career Doctors Quit the Army? April
275

Says Doctors on Draft Boards Waste Taxes.
Sept. 289

NURSES

'335,000 Nurses Aren't Nearly Enough.' April
264

Congress Told About Nursing Shortage. May
244

OFFICES

Easy Upkeep Was the Aim in This Office.
April 144

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SUBJECT INDEX TO MEDICAL ECONOMICS

Plants for Your Office. July 116

Stop That Thief! July 133

The Best Three-Man Office I've Seen. Aug.
106

How Large Should Your Medical Building Be?
Sept. 310

This Doctor Really Built His Dream Office.
Sept. 134

OSTEOPATHS

Acceptance of D.O.s. May 4

Remove the Stigma? May 97

Single-License Plan. Aug. 4

D.O.s Acting More Like M.D.s Every Day.

Sept. 274

D.O.s Desire Peace. Sept. 6

PATIENT RELATIONS

Deplores Treatment of Children in Hospitals.
April 279

Peace-of-Mind Insurance. April 21

Says Future M.D.s Must Learn Bedside Man-
ner. April 256

Should Cancer Patients Be Told the Truth?
April 228

The Trouble With Desks. April 60

How to Lose Patients: Make 'em Wait. May
288

New Look at the Case. May 21

New Medical Students Get Bedside Training.
May 253

Patient Referrals. May 77

Some Tips on Interviewing. May 167

Decries Too Mechanical Care of Patients. June
270

Deduction for Delays. June 26

Raps Patients for Lack of Consideration. June
252

Ceremonial Plea. July 26

X-Ray Urged. July 50

More Office Calls. Aug. 24

Prescription Prices. Aug. 23

Rise of Faith Healers Called Doctors' Fault.

Aug. 196

Getting Patients to Do What You Tell Them.
Sept. 215

Power of Suggestion. Sept. 21

PRACTICE MANAGEMENT

Safeguarding Your Practice When You Take
Time Off. April 126

Why Not Use Charge Slips? April 148

New Light on Itemizing. Aug. 117

No Appointments Here. Aug. 46

A Way to Keep Records of Phone Talks. Sept.
227

Looking Toward Liquidation. Sept. 97

PRESCRIBING AND DISPENSING

Drug Samples. April 21

Dispensing Headache. May 50

Oral Prescriptions. July 4

Prescription Prices. Aug. 23

Rules for Rx's. Aug. 80

About Dispensing. Sept. 46

Are Your Patients Getting Counterfeit Drugs?
Sept. 113

Prescription Trends. Sept. 8

Some Druggists Seek More Leeway in Dis-
pensing. Sept. 302

PROFESSIONAL RELATIONS

Cites Need for D.D.S.-M.D. Cooperation.
April 246

Safeguarding Your Practice When You Take
Time Off. April 126

They Prevent Grievances. April 99

Public Health and You. May 179

Reminds M.D.s of Their Debt to Colleagues.
May 278

Says U.S. Needs More Negro Doctors. May
256

Freedom of Expression. June 58

Industrial Practice. June 54

They Keep Score on Staff Physicians. June
109

Too Easy to Oust. June 97

Fee Grab by Hospitals. July 99

My Partner and I Aren't in Competition. July
189

If You Need an Associate. Aug. 112

Urge Southern Doctors to Drop Color Line.
Aug. 214

Color Line Vanishing. Sept. 4

'Let M.D.-Patient Pay.' Sept. 6

Radiology Referrals. Sept. 76

Urge 'Tangible' Thanks for Colleagues' Aid.
Sept. 300

PUBLIC HEALTH

Change in TB Screening. April 6

'Public Health Schools Need U.S. Aid.' April
235

Health Officers' Pay. May 5

Public Health and You. May 179

U.S. Backs Research. June 5

Poll for Health Facts. July 7

Research Grants. Sept. 78

PUBLIC RELATIONS

Doctors Urged to Think Before Speaking.
April 266

How to Combat Tirades Against Medicine.
April 253

Open to Attack. April 28

For the Doctor on the Way Up

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SUBJECT INDEX TO MEDICAL ECONOMICS

They Prevent Grievances. April 99
Wolf Cry. April 26
Civic-Minded Doctors Are Commended. May 276
Doctors Issue Leaflets to Educate Public. May 242
Newspaper Blast Draws Fast A.M.A. Reply. May 282
Tips for Grievance Boards. May 131
I'm No Longer a 'Joiner.' June 163
Physicians Step Up Safety Campaigns. June 255
Doctors Get Advice on Press Relations. July 230
Quack! On Guard! July 216
Wants Quicker Answers From Medicine. Aug. 195
Planners of Medical TV Programs Get Low-down. Sept. 264

QUACKS

The Quactice Builder. May 138
Psychoquacks. June 52
Rise of Faith Healers Called Doctors' Fault. Aug. 196

RECORDS

Why Not Use Charge Slips? April 148
New Forms to Aid M.D.s. May 5
They Keep Score on Staff Physicians. June 109
Keeping Old Records. July 78
Discarding Records. Aug. 54
New Light on Itemizing. Aug. 117
A Way to Keep Records of Phone Talks. Sept. 227
Reproducing Forms. Sept. 75

RESEARCH

Medical Research Gets Unexpected Aid. April 225
Research, Daily Style. May 30
Separate Corporation to Handle Research Funds. June 240
Sources of Medical Funds, 1940-1953. June 5
U.S. Backs Research. June 5
New Mental Health Fund Courts Big Business. Sept. 259

RETIREMENT

This Group Made Good! June 99
Group Practice. July 46
Why Retire? Sept. 22

SOCIAL SECURITY

Social Security. April 78
Social Security. May 77

Social Security Poll. May 52
Change of Heart. July 97
Political Preview. Sept. 7

SPECIALISM

Early Recognition Seen for Industrial M.D.s. April 281

More on Radiology. April 54
Misadventures of an Insurance Doctor. May 106, June 135, July 149
What's a Specialist? May 54
Crime Doctor. June 103
Getting a Start in Industrial Practice. June 124
Insurance Examiners. July 28

Tomorrow's Doctor: What Are His Goals? July 124

Insurance Examiners. Aug. 46
Is the Family Doctor Obsolete? Aug. 161
Radiology Referrals. Sept. 76
Shopping-Center Practice Is Here to Stay. Sept. 100

STATISTICS

How to Lie With Medical Statistics. Sept. 116

TAXES

Tax on Maintenance. April 77
Unwitting Partners? April 5
Convention Deductions. May 78
Short-Term Trusts Offer Income Tax Savings. May 159
Keep That Program. June 54
Tax Refunds. June 77
Cutting Tax Payments. July 77
Doctor's Ethics Plea Fails in Tax Case. July 220
Court Rules Elevator Not Medical Expense. Sept. 290
T-Men Told: 'Crack Down.' Sept. 7
What the Big Tax Revision Means to You. Sept. 150

VETERANS ADMINISTRATION

Congress Backs V.A. May 4
New Pamphlet Questions V.A. Statistics. May 258
Stiffer V.A. Policy. June 4
Home-Town Plan Cuts Veteran Care Costs. Aug. 196
Legion Takes Its Case to the Doctor. Aug. 215

WRITING AND SPEAKING

Cites Shortcomings of M.D.s as Writers. May 286
How to Lie With Medical Statistics. Sept. 116
Offers List of Don'ts to Physician-Writers. Sept. 271

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(1) Sweetman, C. A. J. So. Carolina M. & 49:38, 1951. (2) Marks, M. M. Am. J. Dig. Dis. 18:219, 1951.
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• Index of Advertisers •

Abbott Laboratories, Inc.	
Dayalets	316
Erythrocin	254, 255
Iberol	57
Selsun	186, 187
Tronothane	29
Vi-Daylin	38, 39
Allen Tobacco Company, John	
Cigarettes	166
American Cyanamid Company	
Bulfa Drug Facts	198
American Feisol Co.	
Feisol	50
American Hospital Supply Corp.	
Travert 10%—Electrolyte Solutions	21
Amo Company, Inc.	
Apamide-Ves	188
Clinitene	164
Armour & Co.	
Dial Soap	180
Armour Laboratories	
Armatinic	281
Armyl	61
Bispar	318
Deltamide	222, 223
HP Acthar Gel	15
Nidar	47
Thyrap	56
Tussar	296, 297
Arnold-Stone Laboratories, Inc.	
Americaine Aerosol	16
Averst Laboratories	
Bominal Forte with Vitamin C	245
Chsintrin	71
Mediatric	11
Bass & Black (Div. of Kendall Co.)	
Elastic Stockings	86
Baxter Laboratories	
Travert 10%—Electrolyte Solutions	21
Benton, Dickinson & Co.	
Multifit Syringes	67
Bock-Nut Co.	
Baby Foods	185
Bircher Corporation, The	
Hyfrecator	253
Bischoff & Co., Ernst	
My-B-Den	214
Borchardt Malt Extract Co.	
Malt Soap Extract	293
Borden Company, The	
Chese	220
Beyle & Company	Insert between 288, 289*
Bryant Pharmaceutical Company	Insert between 288, 289*
Bristol Laboratories	
Polycycline	Insert between 256, 257
Burdick Corporation, The	
MW-1 Microwave Diathermy	308
Carbisulphoil Company, The	
Foille	268
Central Pharmacal Co.	
Cenaser	170
Chicago Pharmacal Company	
Tolyphy	205
Ciba Pharmaceutical Products, Inc.	
Femandren Lingueets	269
Metandren Lingueets	168
Pyribenzamine Expectorant	19
Serpasil	51, 173
Serpasil-Apresoline	55, 189
Colwell Publishing Company	
Daily Log	280
Cutter Laboratories	
Polysal	89
Desitin Chemical Co.	
Desitin Ointment	32
DeVilbiss Company, The	
No. 41 Pocket Nebulizer	299
Dictaphone Corp.	
Dictaphone Time-Master "5"	28
Eaton Laboratories	
Furadantin	33, 192
Edison, Inc., Thomas A.	
Edison Voicewriter	17
Edison Chemical Co.	
Dermassage	310
Esta Medical Laboratories, Inc.	
Lanteen	68
Everest & Jennings, Inc.	
Wheel Chairs	156
Fairbanks, Morse & Co.	
Model 1265 Health Scale	225
Fleet Company, Inc., C. B.	
Enema Disposable Unit	314
Florida Citrus Commission	
Citrus Fruit	236
Gardner, Firm of R. W.	
Hyodyn	204
General Electric Co., X-Ray Dept.	
Maxicon ASC	96
Gerber Products Co.	
Baby Foods	163
Gomeco Surgical Manufacturing Corp.	
Portable Aspirator	252
Heinz Company, H. J.	
Baby Foods	42
Hoffmann-LaRoche, Inc.	
Sedulon	81
Gantrisin	Insert between 96, 97
Holland-Rantos Co., Inc.	
Koromex Method	160

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INDEX OF ADVERTISERS

Irwin, Neisler & Co.		
Obocell	182	
Unitensen	34, 35	
 Johnson & Johnson		
Baby Lotion	167	
Elastic Bandage	36	
 Kinney & Company, Inc.		
Ammorid	83	
Emetrol	243	
 Knox Gelatine Co., Inc., Chas. B.		
Gelatine	300	
 Kremers-Urban Co.		
Kutapressin	13	
 Lakeside Laboratories, Inc.		
Dactil	9	
 Lakeside Mfg., Inc.		
Lakeside Utility Cart	268	
 Lederle Laboratories		
Achromycin	24, 25	
Aureomycin Triple Sulfa	213	
Reveripac	226	
 Leming & Co., Inc., Thos.		
Baume Bengue	65	
 Lilly & Co., Eli		
Co-Elorine	259	
Hlotycin	18, 20, 76, 244, 262, 294	
Paveril Phosphate	271	
Sandril	196, 197	
Trisicron	78, 242, 267, 290	
Vitamins	Insert between 160, 161	
 Lloyd Bros. Pharmacists, Inc.		
Roncovite	26, 27	
 Leverillard Co., P.		
Kent Cigarettes	200, 201	
 McNeil Laboratories, Inc.		
Algoston	264, 265	
Butisol-Belladonna	158, 159	
 Maltbie Laboratories		
Malcotran	87	
 Massengill Company, S. E.		
Livitamin	183	
 Mead Johnson & Co.		
Fer-in-Sol	202	
Mucelin	Insert between Poly-Vi-Sol & Tri-Vi-Sol	224, 225
 Medical Case History Bureau		
Info-Dex	288	
 Medical Economics, Inc.		
193, 225, 257		
 Medicone Co.		
Rectal Suppositories	231, 249	
 Merck & Co., Inc.		
Vitamin	88	
 Merrell Co., The Wm. S.		
Kolantyl-Gel	216, 217	
Mercodol with Decapryn	256	
Nitranitol	228, 229	
Tace	IFC	
 Mutual Benefit Life Insurance Company, The		
Managed Dollars Plan	312	
 National Apple Institute		
Apples	23	
 National Drug Company, The		
ACTH	22, 239	
Hesperidin-C	304	
Parenzyme	94, 95	
 Nepera Chemical Co., Inc.		
Choledyl	238	
 Nestle Company, Inc., The		
Arobon	249	
 Ococy-Crystine Laboratory		
Ococy-Crystine	257	
 Ortho Pharmaceutical Corp.		
Radical Tablets	85	
 Parke, Davis & Co.		
Chloromyctin	266	
 Patch Company, The E. L.		
Kondremul (Plain)	66	
 Personalized Gifts Co.		
Medical Charm Bracelet	253	
 Pfizer Laboratories, Div., Chas. Pfizer & Co., Inc.		
Bonamine	93	
Cortril Topical Ointment	75	
Terramycin	230	
 Phillips Co., The Chas. H.		
Milk of Magnesia	165	
 Physicians' Desk Reference		
260, 261		
 Pitman-Moore Company		
Novahistine	306	
 Proctor & Gamble Co., The		
Ivory Handy Pads	BC	
 Professional Printing Co., Inc.		
Histacount	80	
 Ralston-Purina Company		
Instant Ralston	40	
Ry-Krisp	319	
 Raytheon Manufacturing Co.		
Microtherm	247	
 Reed & Carnick		
Lullamin Drops	235	
Tarboris	70	
 Resinol Chemical Co.		
Resinol Ointment	253	
 Riker Laboratories, Inc.		
Pentoxylon	41	
Rauwoldrine	10, 82, 234, 246, 258, 270	
Rauwolloid	286, 287	
Rauwolloid-Veriloid	73	
Serpiloid	14	
 Robins Company, Inc., A. H.		
Donnagel	157	
 Donnatal Plus		
Phenaphen with Codeine	Insert between 64, 65	
Pabalate	176, 177	
 Roerig & Company, J. B.		
Tetracyc Oral Suspension	292	
 Sanborn Co.		
Viso-Cardiette	72	
 Sandoz Pharmaceuticals, Inc.		
Bellergal	274	
 Schering Corporation		
Chlor-Trimeton	Insert between 32, 33	
Coricidin		

INDEX OF ADVERTISERS

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Scholl Mfg. Co., Inc., The	
Arch Supports	219
Sedgwick Machine Works	
Elevators	294
Sharp & Dohme, Inc.	
Penalev	IBC
Sherman Laboratories	
Gericaps	194
Shield Laboratories	
Riasol	92
Sklar Mfg. Co., J.	
Surgical Instruments	288
Smith-Dorsey	
Crystoserpine	48
Rautensin-Rauvera	52, 53
Smith, Kline & French Labs.	
Acnomet Cream	206
Daprisal	43
Drilitol	90, 91
Eskaphen B	44
Teldrin Spansule	282
Thorazine	27
Vascort	73
Smith Company, Martin H.	
Expasmus	62, 63
Squibb & Sons, E. R., Div. of	
Mathieson Chemical Co.	
Pentids	284
Rau-Sed & Raudixin	84
Standard Laboratories	
Veracolate	278, 279
Strasenburgh Co., R. J.	
Skopolate	232, 233
Strong Co., F. H.	
Cholegestin—Tablogestin	19
U. S. Brewrs Foundation	
Diet Facts	74
U. S. Vitamin Corp.	
Vi-syneral Vitamin Drops	38, 39
Upjohn Company, The	
Biosulfa	255
Cycloesterin Tablets	44
Erythrofusfa	255
Pamine 174, 175, 190, 191, 240, 241, 272, 273	
Wampole & Company, Inc., Henry K.	
Clortran	218, 219
Wander Company, The	
Ovaltine	173
Warner-Chilcott Laboratories	
Anusol	237
Agoral	12
Gelusil	240
Peritrate	302
Tedral	504
Welch Allyn, Inc.	
Diagnostic Instruments	295
White Laboratories, Inc.	
Aspergun	8
Dramcillin-300 Suspension	48, 49
Mol-Iron Panhemic	282, 283
Sulfathiazole Gum	291
Whitehall Pharmacal Company	
Anacin	58, 59
BiSoDoL	184
Whittier Laboratories	
M-Minus 5 & Ertron	273
Winthrop-Stearns, Inc.	
Synephricol	220
Wyeth, Inc.	
Sulfose	291

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Memo

FROM THE PUBLISHER

Change of Pace

"Some medical editors take their readers too seriously. Or they approach them too much in terms of their *professional* interests and not enough in terms of their *human* interests. A man may be a doctor; but first he's a person. The most welcome journal is the one that's as interesting to the man as it's useful to his practice."

So writes one of our readership consultants. And we heartily agree with him.

Take MEDICAL ECONOMICS as an example. It's primarily a business magazine; but we try to vary the reader's diet by printing plenty of articles about the human side of medicine, too.

Sometimes the results surprise us. Sometimes we discover that an article not only makes good reading but, in unexpected ways, also proves useful.

A case in point is the picture story, "American in Vienna," that we published in June. A light-hearted account of life and medicine in the waltz country, it described skiing in the Tyrol as well as surgery in the Krankenhaus.

We were confident that the article

would interest you. But we didn't expect it to have much practical value. Yet it was hardly in print before we learned how wrong we were.

Inquiries about how to arrange for study in Vienna began to pour into our office with every mail. Many readers wrote directly to Austria. The American Medical Society of Vienna reports that it got 215 letters from U.S. doctors in the first six weeks after the article appeared.

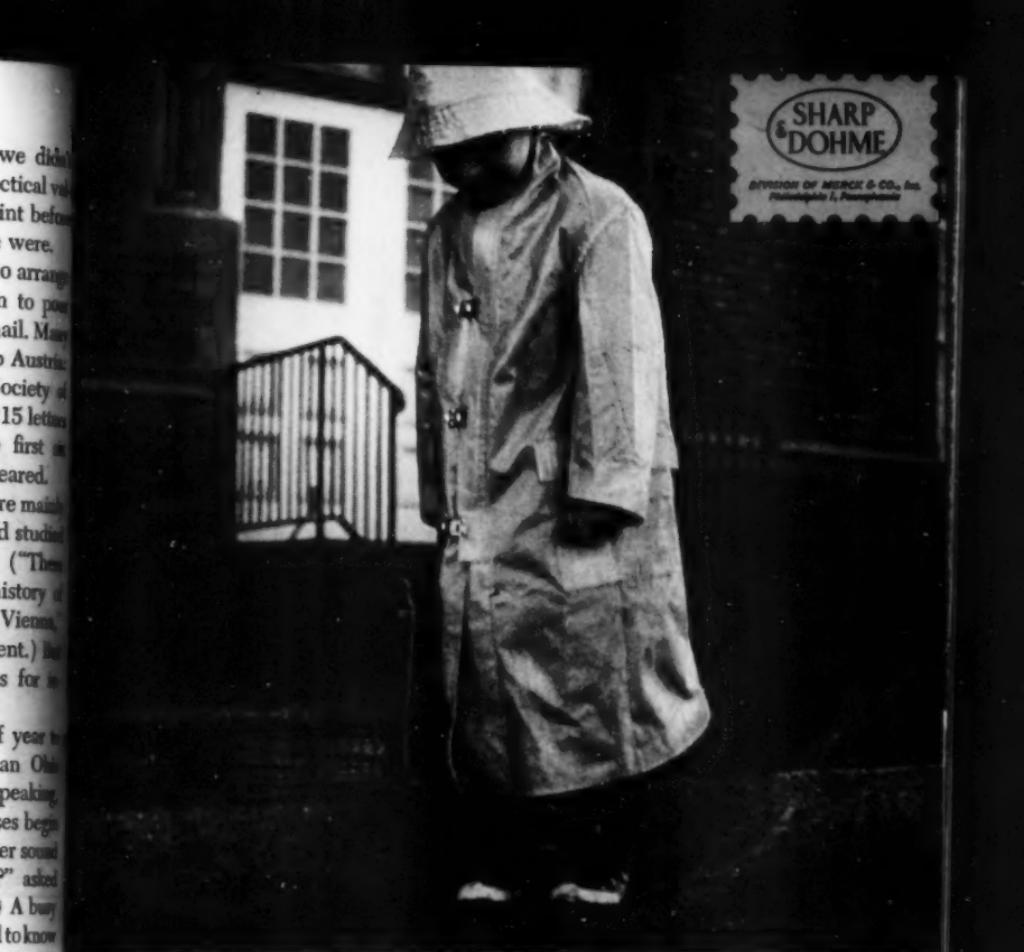
A few of these letters were mainly reminiscences of men who'd studied in Austria before the war. ("There was no teaching in the history of medicine comparable to Vienna," wrote one nostalgic ex-student.) But the majority were requests for information.

"What's the best time of year to come to Vienna?" asked an Ohio pathologist. (Medically speaking, any time is good; new courses begin monthly.) "Does Vienna offer sound training in plastic surgery?" asked a young New Yorker. (Yes.) A busy Western practitioner wanted to know what was the minimum refresher course he could take. (Thirty days.)

Most striking of all, we've heard of at least eight doctors who packed their bags after reading the article and started for Vienna then and there.

Thus a story we printed chiefly for fun served a useful purpose as well. Which just goes to show that in publishing, as in medicine, the side effects can be significant.

—LANSING CHAPMAN



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